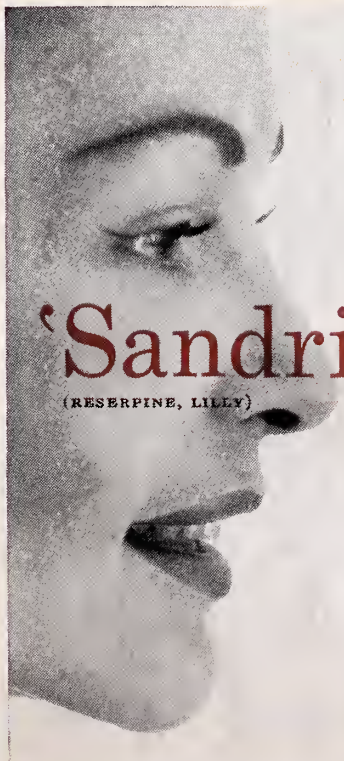
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SEPT.-OCT.
1956

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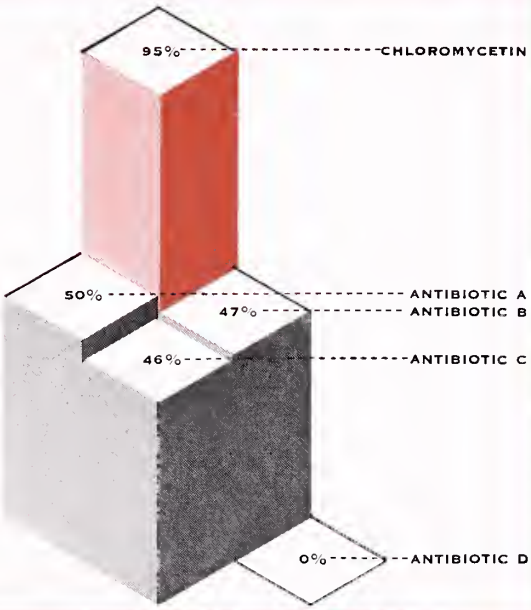
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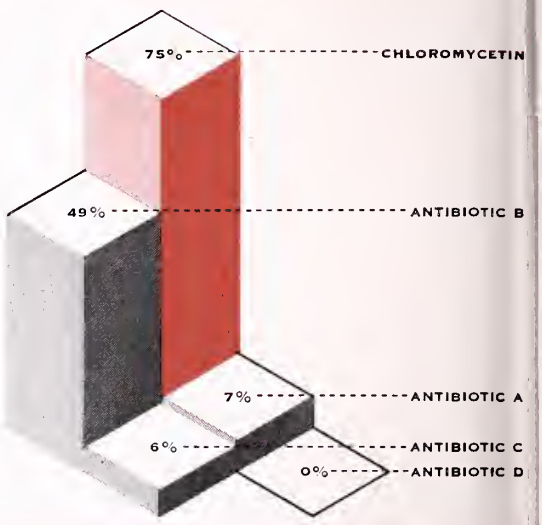
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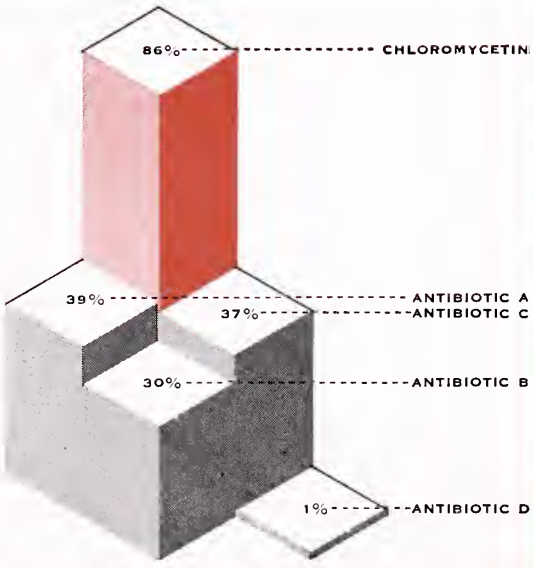


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(148-227 STRAINS)

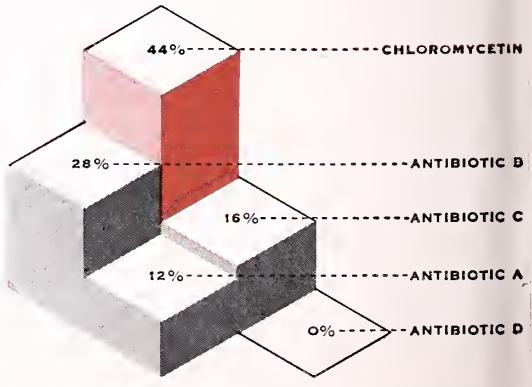


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References: (1) Felix, N. S.: *Pediat. Clin. North America* 3:317, 1956. (2) Joron, G. E.; Fowler, A. F.; de Vries, J.; Reid, G., & Mathews, W. H.: *Canad. M. A. J.* 73:956, 1955. (3) Weil, A. J., & Stempel, B.: *Antibiotic Med.* 1:319, 1955. (4) Perry, R. E., Jr.: *North Carolina M. J.* 16:567, 1955. (5) Jones, C. P.; Carter, B.; Thomas, W. L., & Creadick, R. N.: *Obst. & Gynec.* 5:365, 1955. (6) Murphy, F. D., & Waisbren, B. A., in Murphy, F. D.: Medical Emergencies: Diagnosis and Treatment, ed. 5, Philadelphia, F. A. Davis Company, 1955, p. 557. (7) Altemeier, W. A.; Culbertson, W. R.; Sherman, R.; Cole, W.; Elstun, W., & Fultz, C. T.: *J.A.M.A.* 157:305, 1955. (8) Horton, B. F., & Knight, V.: *J. Tennessee M. A.* 48:367, 1955.

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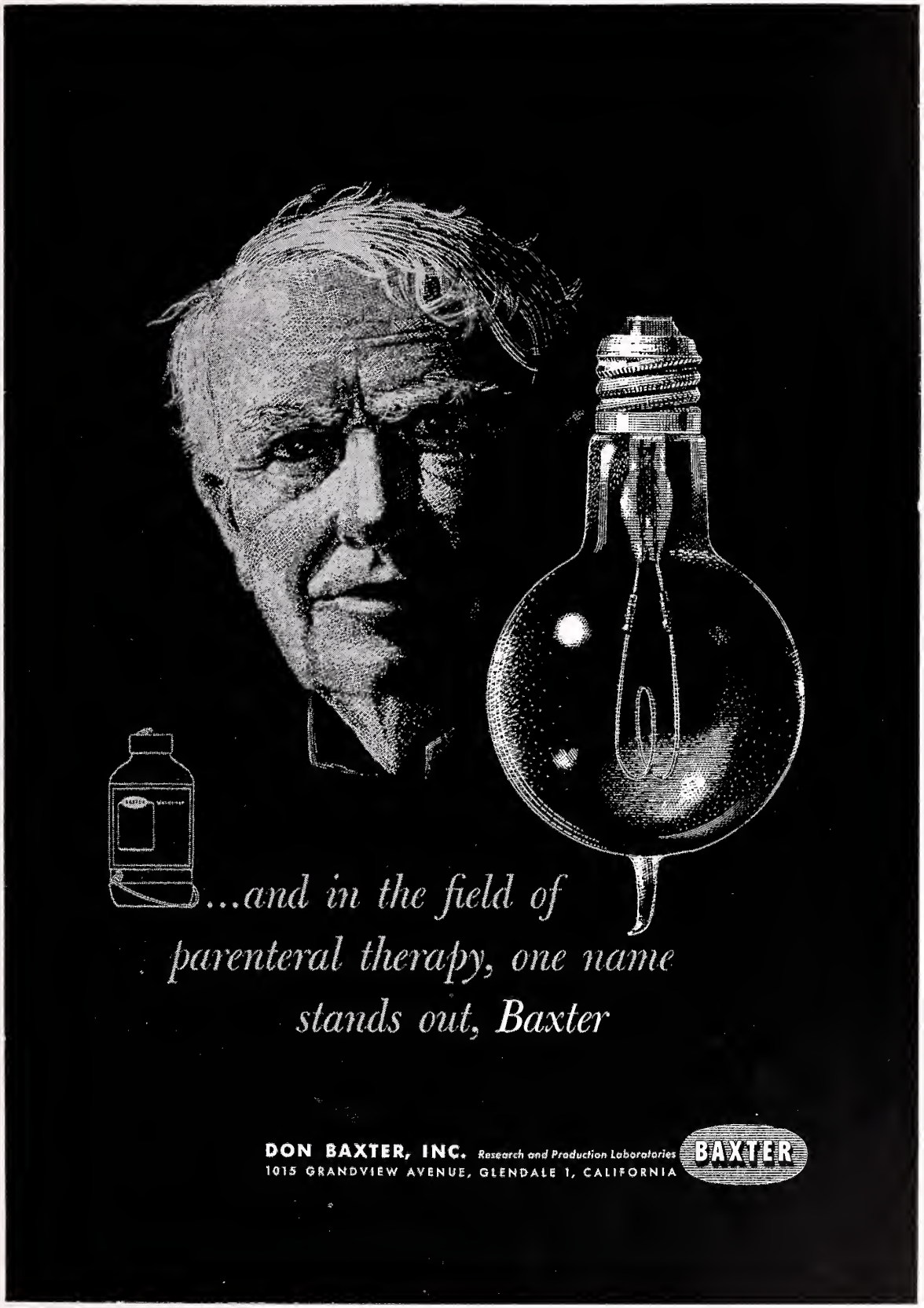
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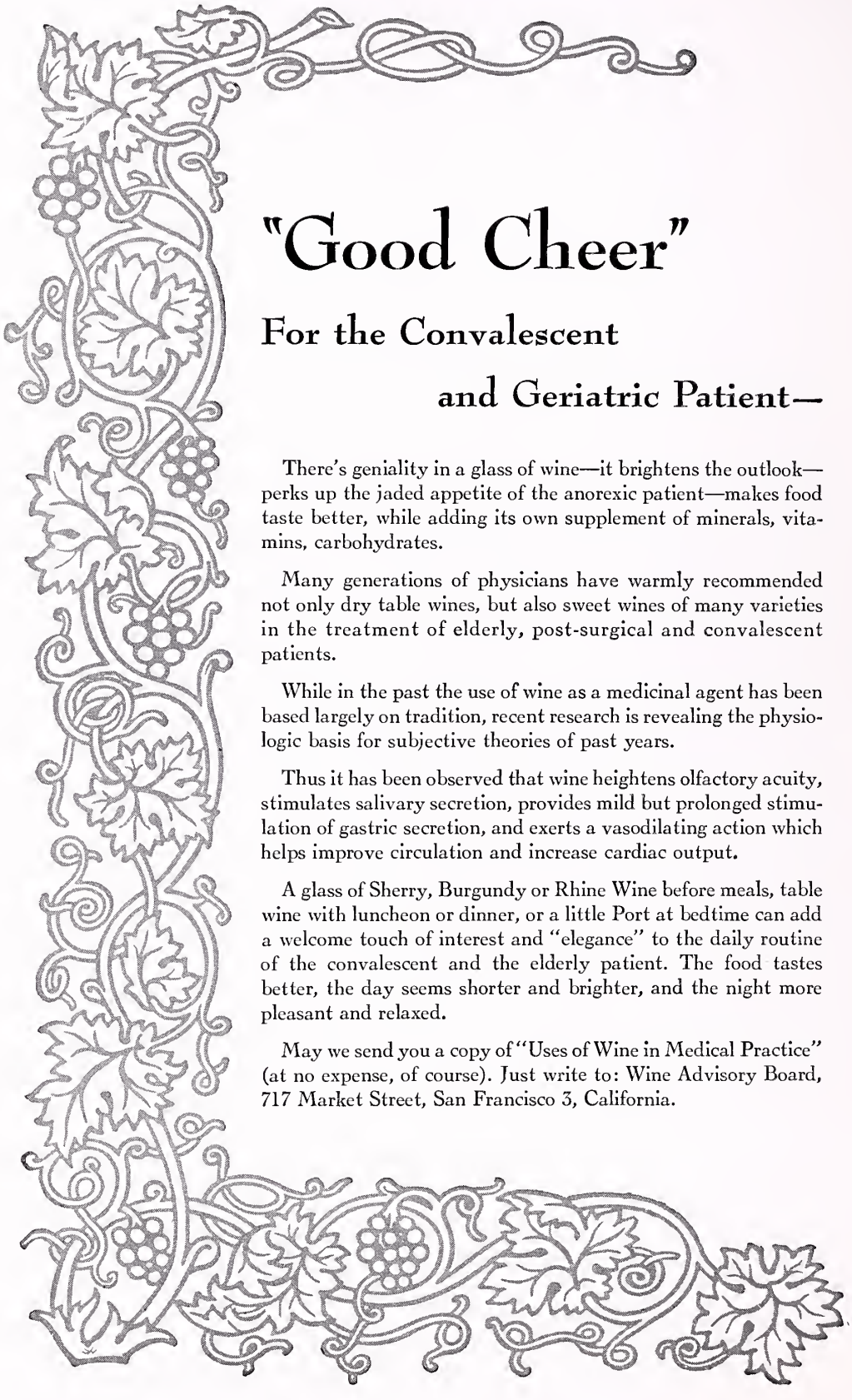
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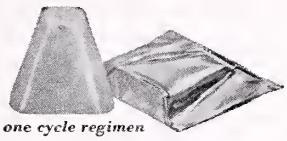
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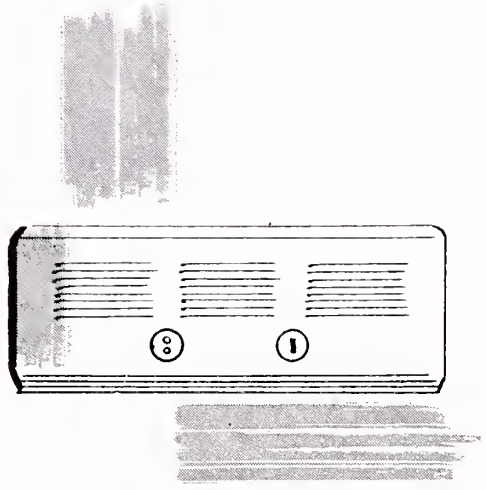
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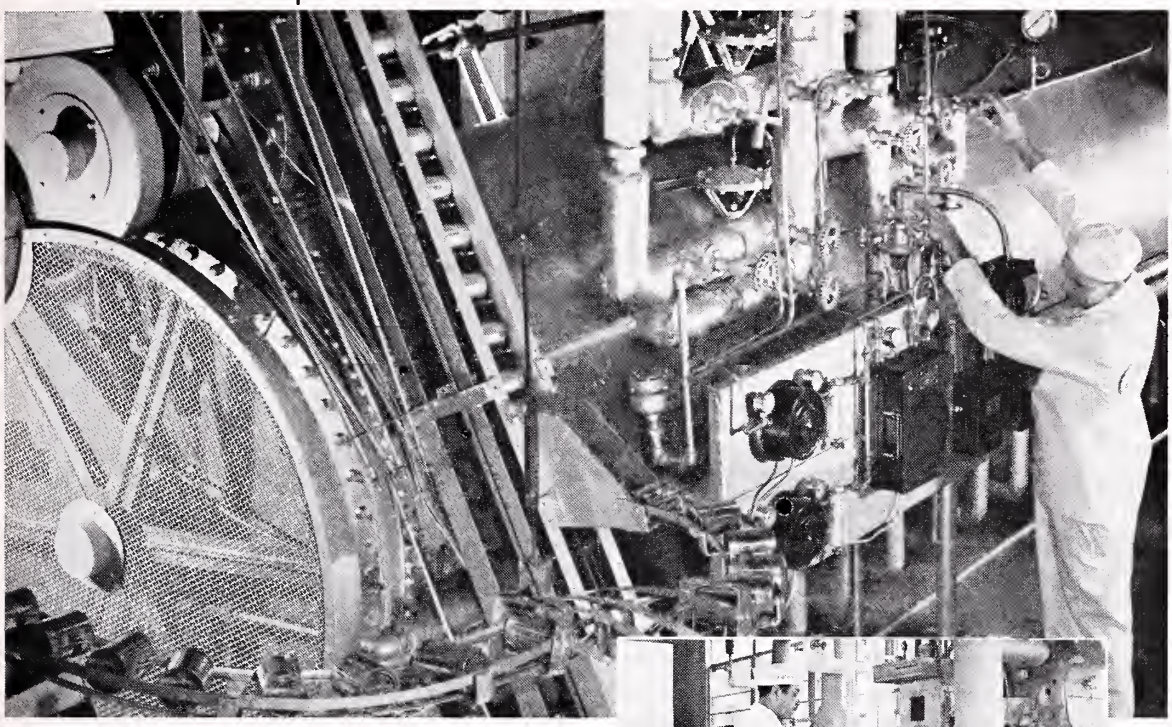
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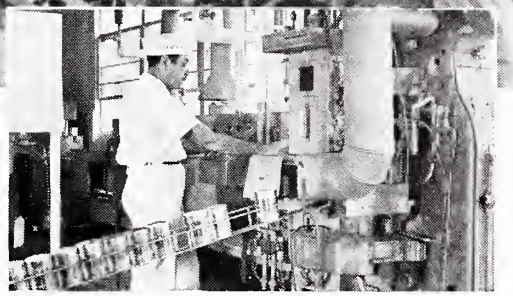
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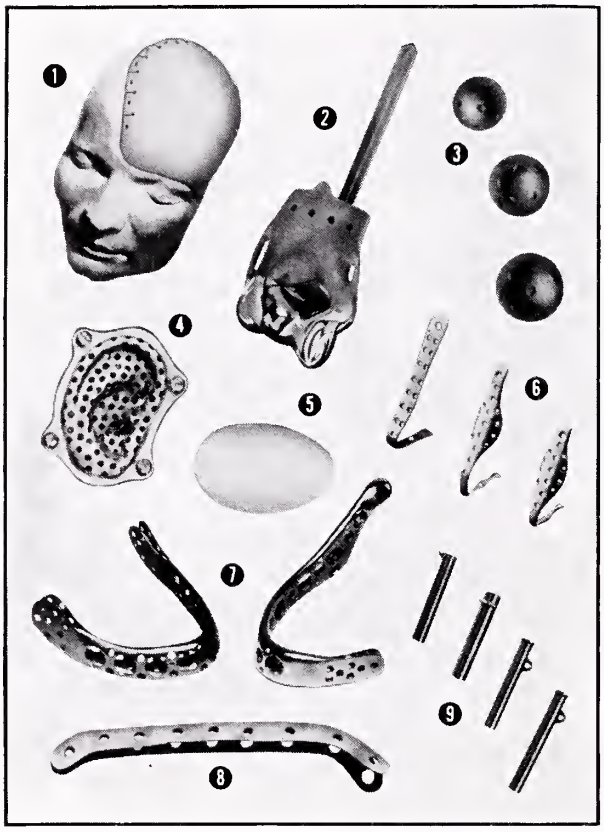
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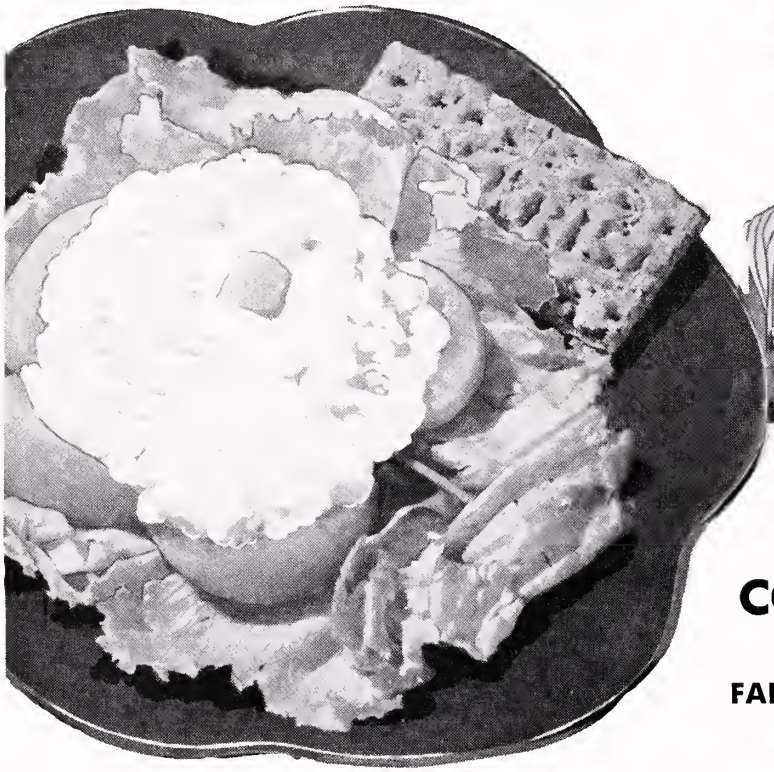
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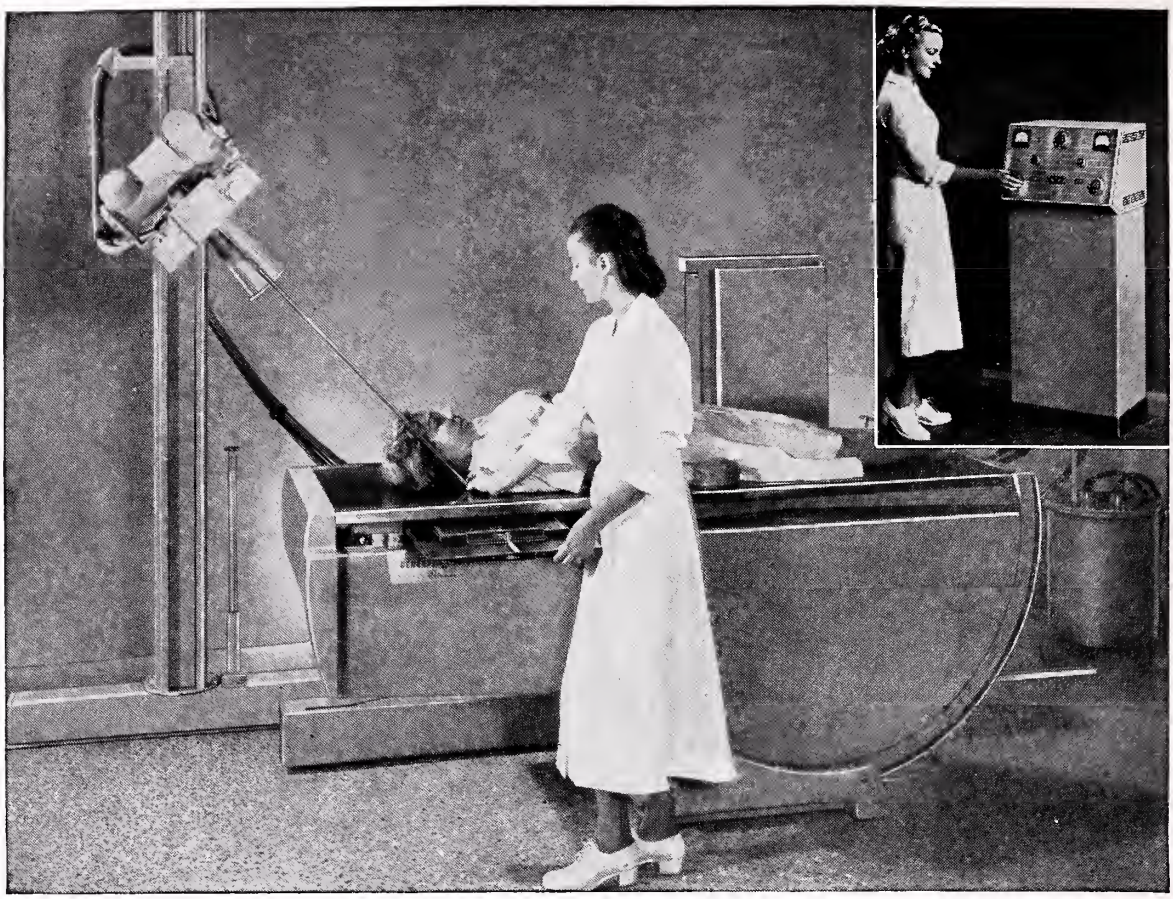
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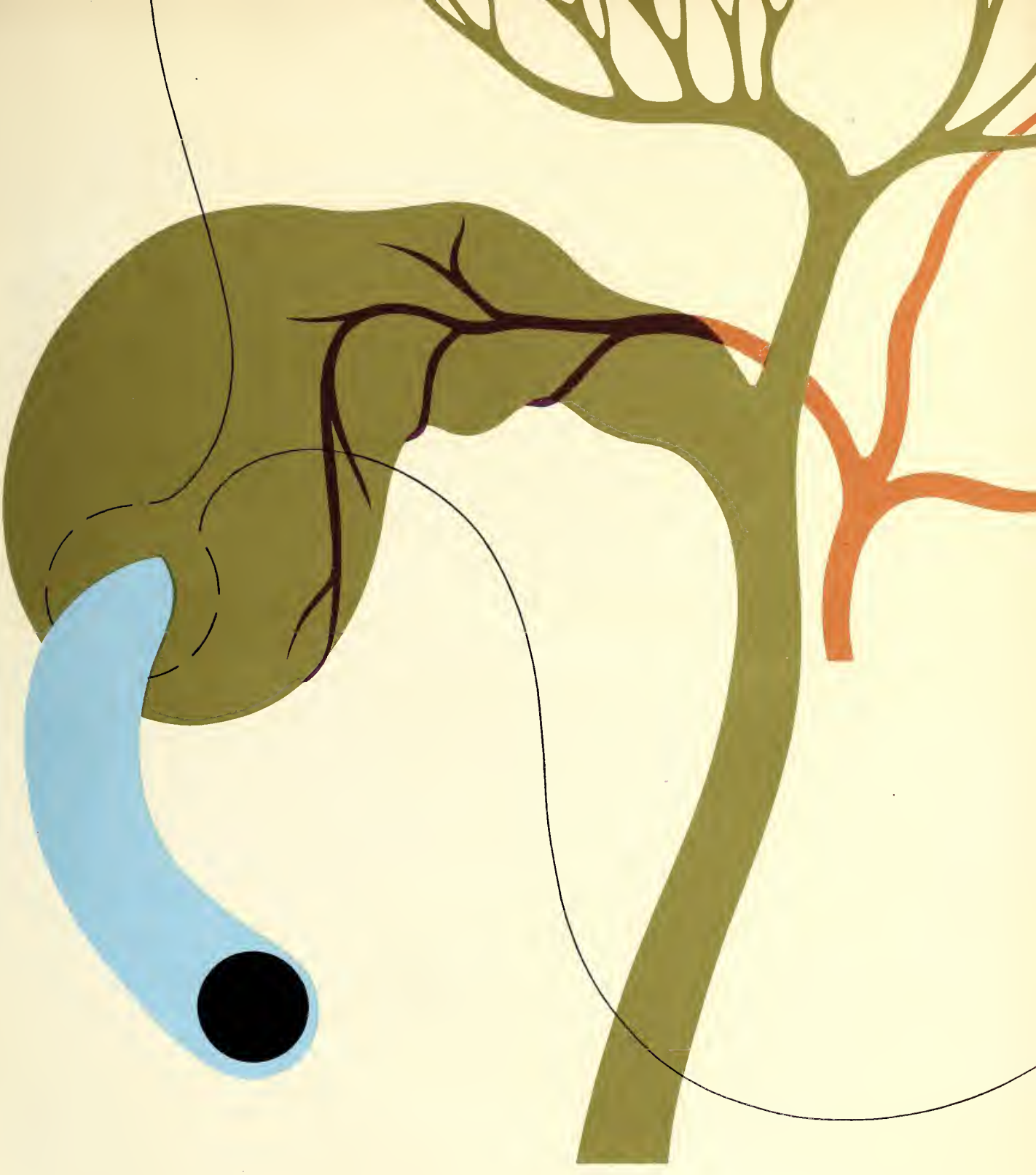
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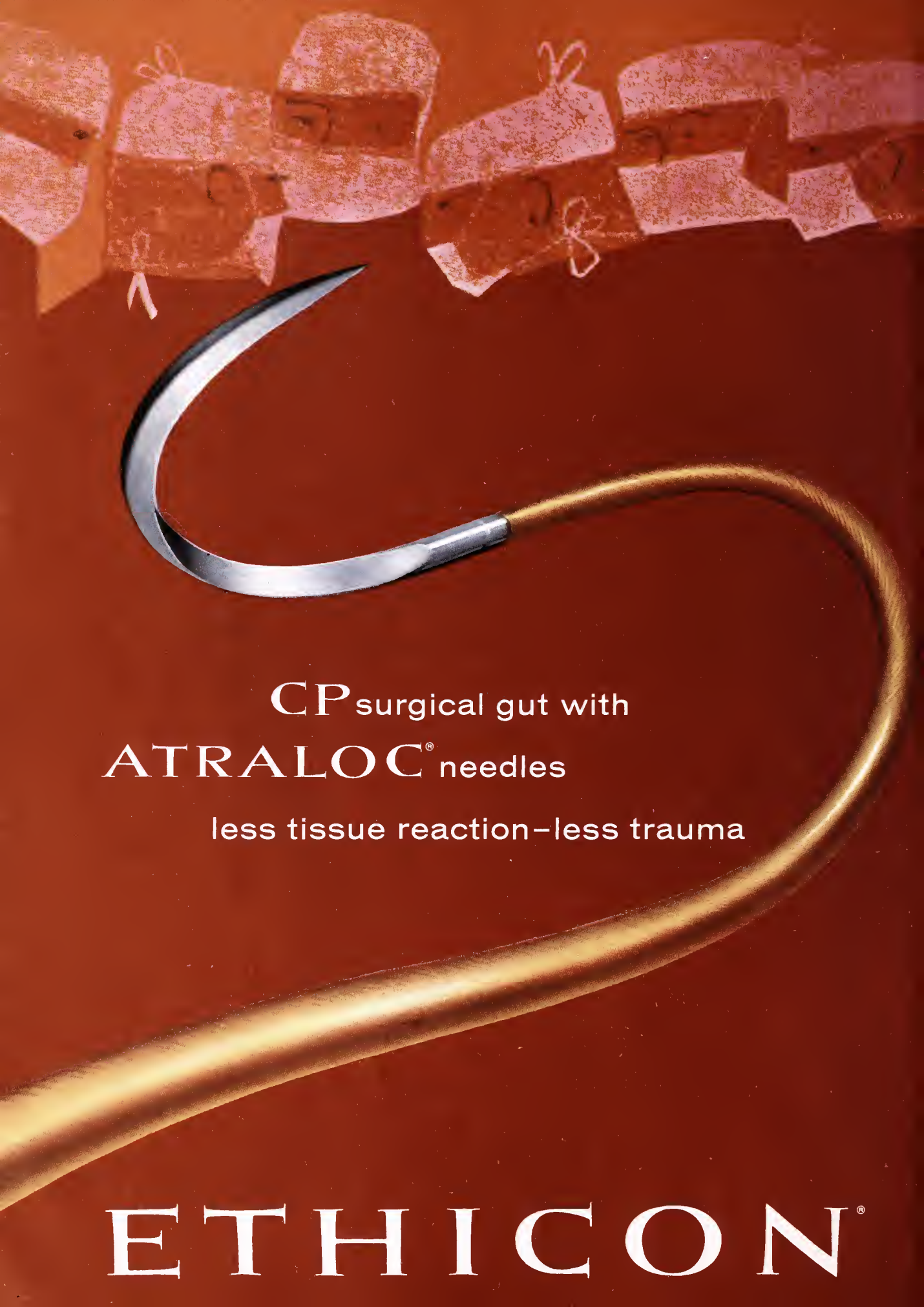
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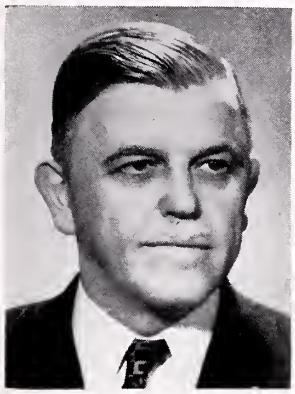
PHYSIOLOGICAL DIFFERENCES PRODUCED BY RACE AND DIET

Other Than Vitamin and Mineral Deficiencies

A. C. IVY, Ph.D., M.D., D.Sc., LL.D., Chicago

Races are uncertain entities, and few valid conclusions can be drawn as to their relation to disease. Outstanding dangers from our diet are: too much food, failure to clean concentrated sweets from the teeth after eating, irritating the gastric mucosa with burned fats, and perhaps contributing to carcinogenesis by eating certain food dyes.

IT has been said that we are what we eat and drink. This is true in the sense that recent evidence indicates that all the tissues in the body are renewed every two years, and not every seven years as we once said to be true of the skin. But how what-we-eat and drink is utilized by the living processes in our body to produce the complex structure, or anatomy, and the multitude of different and complex functional activities, or physiology, is dependent on heredity.



DR. IVY

Can Physiological Differences Occur in Different Races?

Heredity determines our structure and internal environment, except as modified during development in utero by the diet and infectious diseases of the mother. After birth, the structure and internal environment of our body are subject to being modified by our food and drink, by the climate, by infectious disease and parasites, and by various types of injurious agents.

There are two great laws of biology or of evolution which have determined our hereditary characteristics. The first is the "law of variation"; the other is the "law of adaptation." The law of adaptation states the obvious, namely, that every organism must be adjusted or adapted to its environment in order to survive. The law of variation, simply stated, points out the fact that no two individuals are alike in regard to structure and function.

The living organism represents a highly unstable physicochemical system which operates magnificently and wondrously within certain limits of variability about an average normal state. Its physiology and structure disintegrate when conditions go beyond these tolerated limits of variation. Our heart rate, respiratory rate, body temperature are different from that of others. Yet, when they go beyond a certain range, the signs and symptoms of disease result. Some individuals tolerate heat much better than others. This means that the machinery for keeping their body temperature from rising to dangerous limits is more efficient than that of the less tolerant. Some individuals recover from an infectious disease, such as measles, more quickly than others. This usually means that their machinery for overcoming infectious disease is more efficient than the less tolerant.

These well known facts are pointed out to show that on the basis of the laws of variation and adaptation it is possible for different races of people to be different not only from the viewpoint of their anatomy, but also their physiology. But, if the differences were large enough, then there would be a species difference, and the so-called races, or long-time isolated groups of the human species could not inter-breed. So, the question really is:

Can Mankind Be Divided into Sub-Groups on the Basis of Quantitative Differences in Physiological Processes?

First, let us consider the subgroups into which mankind has been classified on the basis, in most cases, of quantitative differences in the form of the body and its superficial parts. When we look at our friends or at pictures of people who live in different geographical regions, it is very obvious that people differ superficially regarding their architecture. Nevertheless, the anthropologists have had great difficulty in classifying different groups of people on such a basis. They find, perhaps with a few exceptions, that the differences

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are of degree rather than of kind[1]. On the basis of measurements of the skull, the color of the skin, the stature and nose form, hair form, and various combinations of these measurements, three different subgroups have emerged: the Caucasoid, the Mongoloid, and the Negroid.

Mankind has also been classified on the basis of blood groups (serologic differences) and body form as related to endocrinologic or hormone functions. On the basis of the frequency distribution of the blood groups A, B, O, N, M, and Rh, six different subgroups of people have been recognized, namely the Early European or Basque, the European or Caucasoid, the African or Negroid, the Asiatic or Mongoloid, the American Indian, and the Australoid. These peoples have been geographically isolated so long reproductively that they have statistically distinct blood group types. The sickling phenomenon of the red blood cells exists in one Negroid subgroup. About 20% of the 200,000,000 persons living in Africa, south of the Sahara, exhibit the sickling phenomenon. Endocrinologically, it is not certain whether pygmies are the result of an early cessation of the production of the growth hormone, or an early ossification of the epiphyses. Neither are we certain concerning the extent to which the pituitary gland is concerned in those groups known for their large stature. The increase in height of present day American children, of Mexicans reared in the U. S. A., and of Japanese and Chinese reared in Hawaii is probably a dietary effect, or the effect of less physical labor leading to later ossification and closure of the epiphyses and taller growth.

Superficial structure and form seem to vary more than the basic structure and functions required for muscular efficiency and power, intelligence, freedom from disease, and longevity, or those factors required for survival.

According to present knowledge, there appear to be more true inborn differences or so-called "errors of metabolism" among the individuals of the same group, race, or nationality than exist between different groups of people anthropologically recognized as different races.[2] There is no known group of physiological characteristics, other than the production of melanin in the skin and protein in the hair, which render it possible to classify a group of people as Caucasoid, Mongoloid, or Negroid, Australoid, Early European, or American Indian. Further studies on the odor and chemistry of the secretion of the apocrine or sebaceous glands might yield significant results,[3] because the chemistry of the secretion may be different, and hence, different odors may be produced by bacterial action.

Physiological Differences Alleged to be Racial Differences

Some of the physiological differences alleged to be due to a difference in race will be briefly discussed.

Basal Metabolism. The rate at which the body uses oxygen at rest after a 14-hour period of fasting is a basic physiological measurement. It tends to be low in natives of Australia, China, India, and Syria as compared to Europeans and North Americans. But it is not certain whether this is due to diet, climate, and traditional mental attitudes. The extremes between those who live in the north temperate and tropical climates is only 12% on the average.[4] I have the impression that the slight differences observed are due more to a difference in climate and diet than to a true racial difference.

Body Temperature and Cooling. A number of functions are concerned in the regulation of body temperature, such as skin surface in relation to body size, sweating, vasodilation of the cutaneous vessels, relative efficiency of the muscular movements, all of which are subject to acclimatization. It is well established that acclimatization of the individual occurs in tropical climates whether he is white or colored. But whether such a thing as racial acclimatization exists has not been established. The impression that aborigines function better under tropical conditions than immigrants who have lived there for several years has been explained as being due to two factors. One is that the small stature of the natives provides them with a relatively larger skin surface for cooling by radiation, convection and evaporation. The second is that some evidence indicates that Hindus, Negritos, and Malays (a type of Polynesian) have a greater concentration of sweat glands per area of skin and have more areas of skin which can sweat profusely.[5] The first factor is not physiological but physical, and would not represent a type of racial acclimatization. It illustrates, however, that a person of small stature is best adapted for the tropics. A long thin body and extremities would also favor body cooling. The second factor, if true, does represent a racial acclimatization, a natural selection, or "survival of the fittest."

Reproductive Processes. Menstruation begins several years earlier (9 years compared to 14 years) in girls in the tropics. It starts earlier in Eskimos also and among primitive peoples. Climate and race have been alleged to be the cause, although

[1] Boyd, W. C.: Genetics and the Races of Man, Oxford, England, Blackwell Scientific Publications, 1950.
Count, E. W.: This Is Race, New York, Henry Schuman, 1950.
[2] Harris, H.: An Introduction to Human Biochemical Genetics, Cambridge University Press, 1953.
[3] Lewis, J. H.: Biology of the Negro, University of Chicago Press, 1942.
[4] DuBois, E.: Basal Metabolism in Health and Disease, Philadelphia, Lea and Febiger, 1936, p. 151.
[5] Sundstroem.[6] Lewis.[3]

this has not been clearly established.[7] It should be recalled that numerous exogenous causes affect menstruation. When women live closely together, divergent menstrual times may shift until they coincide.[8]

Blood Pressure. The effects of race, climate, age and diet on blood pressure have not been separated. Some reports indicate that a tropical climate has no effect; others, that it has a protracted lowering effect.[7]

Changes Due to Ageing. According to anthropometric measurements, ageing has the same effect on residents of the U.S.A., American Indians, and aboriginal Hawaiians. The relation of race to longevity is obscure.[9]

Racial Susceptibility to Infectious Diseases. The expression "racial susceptibility" to certain diseases means that groups of people who have been geographically isolated from contact with an infectious disease for generations are more susceptible to the disease when they are exposed to it. For example, the American Indian is more susceptible to tuberculosis than the Negro, and the Negro is more susceptible than the descendants of Europeans. The Negro has a great resistance to vivax malaria.[6] He can have the organisms in his body, but show no symptoms. The natural resistance of people who have been exposed to a disease for many generations, as compared to those who have been isolated from it, is believed to be due to the transmission to succeeding generations of non-specific factors (factors not specific to the particular infectious agent) possessed by the survivors of an acute infection. In some cases, it is due to the placental passage of maternal antibodies. The Negro has a natural susceptibility to tuberculosis, syphilis, pneumonia, whooping cough, rickets, sickle cell anemia, and keloid formation; a natural resistance to malaria, diphtheria, the exanthemata, yellow fever, typhoid, hookworm and gallstones.[6]

"Racial susceptibility and resistance" to certain infectious diseases appears to be the best example of a physiological difference due to race. Theoretically, it should occur in any racial group which has been separated from contact with the disease for many generations, and is due to isolation and *not* to "race."

Are Any Physiological Differences Produced by a Combination of Race and Diet?

I have been able to find only three physiological differences probably produced by a combination of diet and race. One is the "racial susceptibility" to tuberculosis, pneumonia, measles, small pox, and whooping cough, which would be exaggerated by a poor nutritional state.[6] A second is the increased susceptibility to rickets in races with dark colored skin, which would be augmented by a deficiency of vitamin D in the diet.[6] The third is that Hebrews in all countries lose the ability to produce insulin adequately from 1.5 to 2 times more frequently than gentiles which is believed to be due to hereditary inbreeding.[10] The onset and progression of insulin deficiency in animals are exaggerated by a high fat diet.[11] There is a correlation in classes and races of people between the fat consumed and the diabetic death rate.[12] And overweight is present in 75% and marked obesity in 40% of diabetics before the onset of insulin deficiency.[10]

Physiological Differences Produced by Diet, other than Vitamin Deficiencies

The growth, maintenance and repair of the body and its processes, when free from attack by infectious diseases, parasites and physical injury, depend on nutrition, or on food and on such nutrients as vitamins and minerals. Because of interest in producing meat, poultry and dairy products more and more rapidly and abundantly, much has been learned about the relation of nutrition to growth. Relatively little attention has been devoted to the optimum nutrition for maintenance and repair, to guard against degenerative diseases and premature ageing. We have been interested primarily in getting poultry, pigs and cattle to the market in a hurry, and not in maintaining them for a healthy old age (eugeria; normal ageing). In human nutrition, we are just beginning to realize fully that there are serious problems other than those which pertain to calories, minerals and vitamins.

In *under*-fed countries, the problem is to provide food to prevent famine and partial starvation. In *well*-fed countries, our nutritional problem is to prevent nutritional disturbance due, *first,* to over-eating and the resultant overweight with its deleterious consequences; *second,* to partaking of over-processed food which results in harm from "purification," added injurious agents (dyes), and overheating; and, *third,* to improper amounts of the basic food stuffs, protein, carbohydrates and fats, including cholesterol.

The solution to the problem of over-eating and over-weight is to educate the public regarding the

[6] Sundstroem, E. S.: Physiological Effects of Tropical Climate, Physiol. Rev. 7: 320 (April) 1927.
[7] Novak, E.: Menstruation and Its Disorders, New York, D. Appleton and Co.; 1931, p. 102.
[8] Kleitman, N.: Biological Rhythms and Cycles, Physiol. Rev. 29: 1 (Jan.) 1949.
[9] Cowdry, E. V.: Problems of Ageing, ed. 2, Baltimore, Williams and Wilkins Co., 1942, p. 80.
[10] Joslin, E. O.: The Treatment of Diabetes Mellitus, ed. 6, Philadelphia, Lea and Febiger, 1937.
[11] LaZarow, A.: Factors Controlling Development and Progress of Diabetes, Physiol. Rev., 29: 48 (Jan.) 1949.
[12] Himsworth, H. P.: Diet and Incidence of Diabetes Mellitus, Clin. Sci., 2: 117 (Sept.) 1935.

consequences, and to persuade them not to overeat. However, much research will have to be done before the solutions of the latter two problems become available.

In my own research activities, I have been interested, *first,* in the relation of refined and concentrated sugar to the cause of dental caries; *second,* in the relation of hot foods, overheated fats or fried foods, and non-toxic food dyes to gastritis and gastric cancer; and, *third,* in the relation of dietary cholesterol and fat to cholesterol metabolism and atherosclerosis.

Dental Caries

In relation to dental caries, I have wondered why the aborigines of the Hawaiian Islands had excellent teeth when consuming their primitive diets, and then quickly developed caries when they started to consume concentrated sweets.[13] This has been true of all peoples isolated from civilization. This is one of the few illustrations known showing the relation of a change in diet to the development of a disturbance in structure and function without the existence of a vitamin and mineral deficiency. The fact cannot be denied. What was and still is the cause? Either concentrated sweets or a direct-acting infectious agent must have been involved. It was not carbohydrate food, because the native Hawaiians consumed much "poi," and had good teeth, like the natives of the island of Tristan Da Cunha, who also consumed a high carbohydrate diet. But concentrated starch, or a diluted sugar solution in the mouth, is quite different from a concentrated sugar solution. A concentrated sugar solution is hypertonic, has a high diffusion gradient and can diffuse into the teeth, along with bacteria which produce acid, which in turn dissolves the enamel.

This does not mean that one has to stop eating a little candy, or waffles with syrup. It does mean that one should brush the teeth, wash the mouth with some water, or use a toothpick after eating, which should be done whether or not you like to eat concentrated sweets.

Hot Foods and Drinks

It is known that a cancer of the skin sometimes arises in the scar of a burn.

A temperature of 122° F. (50° C.) applied to the skin for one or two minutes will cause injury. A temperature of 126° F. (52-54° C.) applied to the mucosa of the stomach for two or three minutes will cause injury. We found that about 10 per cent of people take coffee and tea, soup, and mushes at a temperature of from 168° F. to 176° F., or hot enough to burn the mucosa of their stomach.[15]

Overheated or Burned Fats

We have found that fats when heated to the flash point, or to about 600° F., or to the point of turning dark brown or black in deep frying, or in roasting, or around the edge or on the bottom of pans, when fed to rats, will cause gastric irritation and gastritis, especially if they are fed with a low protein diet. Heating fat at a high temperature splits it into irritating fatty acids. Of course, physicians have for many years advised patients with dyspepsia *not* to eat greasy or fried foods. We now know why[14] they should not do it.

Furthermore, our data show without a doubt that "overheated" or "burned" fats when injected under the skin of a rat will cause a cancer to develop in a statistically significant number of cases. This is another reason why we should be careful about overheating fat. A temperature of 350° F. is enough heat for cooking, and there is some evidence indicating that fat heated to 428° F. contains a cancer producing substance.

Certain Certified Food Dyes

With the idea in mind that certain certified food dyes might lead to or predispose to the development of cancer, 27 dyes were mixed with the food and fed. After from 6 to 20 months, five of the rats developed gastritis of the hypertrophic type; five developed cirrhosis of the liver; one developed a tumor of the liver; and seven developed lymphomas of the mesenteric lymph glands. Two of the dyes which produced tumors also produced fibrosarcoma when injected under the skin.[15]

There are other things we eat and drink that are under suspicion, but have not yet been investigated.

Summary and Conclusions

It is theoretically possible for significant physiological differences to develop in "races" of people. The study of superficial differences, such as the shape of the skull, the color of the skin, the stature, the form of the nose, and the form of the hair, has rendered it possible to classify mankind into three groups, namely, Caucasoid, Mongoloid, and Negroid. A study of blood groups has rendered it possible to recognize three additional groups, the Australoid, American Indian, and Early European (Basque). But a search for true physiological differences has *not* resulted in any classification of "races" or groups of mankind. There are more physiological variations among the individual members of a so-called "race," than there are between "races."

There is one striking physiological difference between groups of European and Asiatic people

[13] Price, W. A.: Nutrition and Physical Degeneration, Redlands, Calif., 1945.

[14] Marshall, J. A.: Dental Caries, Physiol. Rev., 19: 389 (July) 1939.

[15] Ivy, A. C.: Gastroenterology, 28: 345 (March) 1955.

and groups of people who for centuries have been geographically isolated. Those people who have been isolated are susceptible to diseases, such as small pox, tuberculosis, syphilis, measles, to which Europeans and Asiatic people have been exposed for many generations. This is *not* a true racial difference, because it is characteristic of any group of people isolated geographically for centuries.

Other physiological differences which at one time were thought to be racial characteristics are due in part or whole to factors such as climate, diet, and ways of living. For example, menstruation begins earlier among primitive peoples, but this has not been shown to be due either to race or climate. A tropical climate appears to be important, and ways of living also appear to be important. Most everyone can acclimatize to the tropics. Persons of small stature are more tolerant to heat and humidity, chiefly because they have more skin surface in relation to body size, which aids in keeping the body cool. Most natives of the tropics are small in stature, or have long thin bodies and extremities. There is some evidence indicating that people who live in the tropics (Hindus, Negritos, Malays) have more sweat glands than people who live in the temperate zone.

The only instances in which an alleged racial physiological difference appears to be combined with diet to increase the morbidity and mortality of a disease, are: tuberculosis, pneumonia, whooping cough, small pox, measles, and rickets, and diabetes mellitus in Hebrews.

In human nutrition we are just beginning to realize fully that there are serious problems other than those which pertain to calories, minerals, and vitamins. In underfed countries, the problem is to provide food to prevent famine and partial starvation. In well-fed countries, our nutritional problem is to prevent nutritional disturbances due (1) to overeating of "calories," (2) to overeating of concentrated sweets as related to dental caries, (3) to the addition of injurious agents to processed foods, such as certain food dyes, (4) to the removal of substances necessary for health by too much processing, (5) to overheating or burning fat, (6) to eating hot foods, (7) to taking alcoholic beverages instead of adequate food, (8) to eating too much fat and too little protein, and (9) to eating too much fat and cholesterol, which is related to arteriosclerosis and diabetes.

Eating concentrated sweets without cleaning the teeth with a brush, or by swishing water in the mouth, or by using a tooth pick, is most probably the cause of dental caries. Hot foods and drinks and burned fats, and certain certified food-dyes must be suspected as causing or predisposing to gastritis and gastric cancer, and possibly cirrhosis of the liver and lymphosarcoma.

EFFECTS OF RACE, CLIMATE AND DIET ON THE HEMATOPOIETIC SYSTEM

PAUL REZNIKOFF, M.D., New York

Race, climate and diet all influence the hematopoietic system, sometimes in very specific ways. It may be that the atomic age is bringing us additional problems in this field.

THE HEMATOPOIETIC system should need no description to a medical public. However, it has come to include not only the blood forming organs and the peripheral blood, but also the spleen in conditions in which the blood is not primarily involved.



DR. REZNIKOFF

Race, on the other hand, is very difficult to define without considerable anthropological knowledge. However, if one remembers that many of our medical terms will not stand the test of etymological scrutiny we may discuss racial problems in a manner which, while not exactly scientific, nevertheless may be understood by physicians.

Climate and diet should give us no trouble if we consider variations of practical significance.

This presentation will deal with clinical problems and not experimental or animal studies and is designed to stimulate questions rather than to present an exhaustive survey of the subject.

Race

Anemia. It is generally agreed among hematologists that pernicious anemia is much more prevalent among Nordics than among other groups.[1] Certainly this is our experience. Another macrocytic anemia, diphyllobothrium anemia, due to the fish tape worm, is most commonly seen among the Finns. However, although 70 percent of the cases are found in this group, it is not entirely a question of race because Swedes, Italians and Japanese are equally heavily infested.[2] Also orthodox Jewish women who taste raw gefuelte fish to determine its seasoning are occasionally afflicted with this disease.

Hemolytic anemia of the familial spherocytic type is not found in any particular race. Turner and his coworkers[3] showed that negroes' erythrocytes are more resistant to hypotonic saline than those of white subjects.

Mediterranean anemia, characterized by hypochromia, microcytosis and fetal hemoglobin when determined by electrophoresis, is seen in the people who live around the Meditarranean Sea and in their descendants. This may be severe, as in Cooley's anemia or merely show the trait (Thalassemia minor), and is inherited as a recessive gene.

Sickle cell anemia and its variants, such as hemoglobin C disease, is found almost entirely in the colored race. Combinations of Mediterranean and sickle cell anemia have also been described.

Hemophilia. Whitby and Britton[4] state that hemophilia has a peculiar predilection for the English and Teutonic races. In our clinic, however, we have seen hemophiliac patients in other groups, certainly in Jews and Mediterraneans.

Polycythemia Vera. Many authors[5] have pointed out that polycythemia vera seems to be most prevalent among Jews of eastern European origin. Whether this is racial or a result of inheritance of a diet is not certain. Askanazy[5] believed that vascular changes are more common in people who have a high fat diet and that eastern European Jews eat more fat than most other people. This observation may be significant because there is some evidence that in polycythemia vera there are vascular changes in the bone marrow.

Splenic Disorders. Gaucher's and Niemann-Pick's diseases, characterized by spenomegaly and involving the reticuloendothelial system, are seen almost exclusively in Jews.

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Presented at the Centennial of the Hawaii Medical Association, April 24, 1956.

[1] Whitby, L. E. H., and Britton, C. J. C.: Disorders of the Blood, ed. 7. New York, Grune and Stratton, 1953, p. 233.

[2] Ibid, p. 282.

[3] Turner, E. L., Bent, M. J., Grant, W. H., and Holloway, G. D.: Icterus Complicating Pneumonia. 1. Corpuscular Fragility in the Normal Negro, Proc. Soc. Exper. Biol. and Med. 37: 481 (Dec.) 1937.

[4] Whitby,[1] p. 393.

[5] Reznikoff, P., Foot, N. C., and Bethea, J. M.: Etiologic and Pathologic Factors in Polycythemia Vera, Am. J. Med. Sc. 189: 753 (June) 1936.

Climate

Anemia. For a long time it was generally believed that anemia was very prevalent in the tropics because many individuals became pale in tropical regions. However, a careful study of blood pictures in the tropics indicates that this idea is a myth.[6] Pallor may be due to the condition of the skin capillaries but not to anemia. Mills[7] states that pernicious anemia is most severe in temperate regions. It may be of interest to note that pernicious anemia is a rare disease in Hawaii.[8]

Polycythemia. It is well known that polycythemia occurs at high altitudes. But most hematologists think that erythrocytosis due to oxygen rarefaction is not like polycythemia vera because there is no leukocytosis, thrombocytosis or splenomegaly in the polycythemia of high altitudes.

Leukemia. Leukemia is a disease which is present in all parts of the world and affects all ages, both sexes, and probably all mammals. However, it has been suggested that its incidence may be influenced by climatic conditions and it is of interest that this disease is supposed to be uncommon in Hawaii.[9]

Diet

Anemia. Anemia occurs most generally among those people who live on a high carbohydrate, low protein, low vitamin and iron diet.[10] This is seen, for example, in countries where sprue is prevalent.[11]

The term tropical anemia is really not characteristic of the climate or of a geographical location because cases of this type are present in temperate zones. A careful study of this condition points to nutritional deficiency as the cause of so-called tropical anemia which is much more common in the tropics.[12]

Favism, caused by sensitization to the protein of the fava bean or its pollen, and characterized by severe hemolysis, is most common where this food is grown and eaten in quantity—southern Italy, Sicily, and Sardinia. A few cases have been seen in the United States.

Hemorrhagic States. A hemorrhagic condition occurs when the diet is deficient in vitamin K.[13] However, such a cause is not nearly as common as in liver disease where the organism is unable to convert this vitamin into prothrombin.

Miscellaneous Conditions

Neutropenia or agranulocytosis, usually an acute condition, characterized by sudden and marked decrease in white blood cells, especially of polymorphonuclears, is most prevalent in those regions where the physicians and consumers keep abreast with "advances" in therapy and "pharmaceutical advertising." It is paralleled by the number of radio and television sets in a community and might be called an index of "civilization." The reason for this is the relationship of agranulocytosis to drugs, and it seems that with the introduction of medications, from the days of aminopyrin to the modern usage of chloramphenicol and chlorpromazine, new cases of this disorder appear. The same may be said of acquired aplastic anemia and thrombocytopenic purpura.

Finally, a word might be said about the future of hematologic disorders in the era of the atomic bomb. We do not know what the long range effects of this weapon may be. Aplasia of the bone marrow occurs in a very short time if enough radiant energy is present in a given area, and leukemia is conspicuously increased in a population of a region a few years after radiation exposure. We do not know, however, the effects of the fallout upon the blood forming organs, or for that matter upon other organs.

One might consider from the above statements that the impact of race, climate and diet upon the hematopoietic system may be profound and often deleterious. But our knowledge of these factors may also permit us to correct, to some extent, certain disorders of our blood. Also, when we compare the effects of race, climate and diet with those of the atomic bomb we might agree with the optimist who said when he stepped out into a terrific blizzard that it was better than nothing.

[6] Wintrobe, M. M.: The Erythrocyte in Man, Medicine 9: 195 (May) 1930.

[7] Mills, C. A.: Otto Glasser's *Medical Physics,* Chicago, The Yearbook Publishers 1: 232, 1944.

[8] McKinley, E. B.; A Geography of Disease, The George Washington Press, Washington, D. C., 1935, p. 21.

[9] Petersen, W. F.: The Patient and the Weather, Edwards Bros., Inc., Ann Arbor, Mich., 1937, vol. 4, part 2, p. 393.

[10] Wintrobe, M. M.: Clinical Hematology, Philadelphia, Lea & Febiger, ed. 3, 1951, p. 368.

[11] Wintrobe, p. 473.

[12] Whitby, p. 262.

[13] Kark, R., and Lozner, E. L.: Nutritional Deficiency of Vitamin in Man, Lancet. 2: 1162 (Dec. 2) 1939. Mackie.[14]

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THE FALLOUT PROBLEM

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Radioactive fallout is dangerous, but the risk it entails is very small, and more than justified by the possibility that the tests which produce it will contribute to prevention of radioactive warfare.

RADIOACTIVE FALLOUT is the radioactivity which falls out of the atmosphere after explosion of a nuclear weapon. The amount of fallout is determined by the nature and amount of nuclear material used, the conditions of explosion and such meteorologic factors as wind and rainfall.



DR. DUFFY, JR.

The fallout problem, according to Dunning,[1] resolves itself into the following questions:

1. What are the radiation problems associated with nuclear weapon testing?
2. What data are available concerning fallout from the past tests and what might this radiation amount to if the tests continue?
3. Finally, what do these data mean? How serious are the risks of residual radiation and radioactive fallout?

When a nuclear weapon is detonated, instantaneous gamma rays are released, of concern for about a mile for the nominal bomb and out to a few miles for high-yield weapons. In contrast, the ensuing radioactive fallout may deposit significant radioactivity more than 300 miles downwind from high-yield weapons. This secondary material emits gamma rays similar to the prompt radiation but of less quantum energy. It also contains the short range beta rays, of particular significance when the radioactive fallout makes direct and sustained contact with the skin, producing "beta-ray burns."

Most of the fallout from the nominal atomic bomb is regional, but the high-yield weapons deposit only one-third or so of their fallout locally. Considerable, perhaps one-half, of the radioactivity finds its way into the stratosphere and it may remain there for a prolonged period during which it may circle the earth several times and settle in a minimal, generally even and measurable fashion.*

So much for the problem—now what do we know as a result of tests to date?

It might be in order to present a few standards with which to measure the effects of radiation.

1. A normal chest x-ray will deliver about 1/10 of a roentgen to the chest. Combined x-ray and fluoroscopic procedures such as angio-cardiography or cardiac catheterization may deliver 200 or more roentgens to a localized area of the body.
2. In contrast, 25 roentgens of gamma radiation delivered in a short time (day or less) over the *whole body* will result in definite although transitory changes in the blood; about 100 roentgens are required for some persons to show radiation sickness; about 400 roentgens of whole body radiation may be lethal to half of the exposed persons.
3. Finally, about 10 roentgens are received in a lifetime from cosmic rays and from naturally occurring radioactivity in the air, water and soil.

Following the March 1954 thermonuclear or hydrogen bomb explosion at the Pacific Proving Ground, an unexpected shift of winds caused a heavy radiation fallout over some of the Marshall Islands.

The highest radiation exposure to any of the island inhabitants was about 175 roentgens. Most of these people gave evidence of radiation sickness. There have been no deaths or, as yet, untoward sequelae. This group is being carefully followed, with particular emphasis on hematologic studies.

A Japanese fishing boat near the Proving Ground was also showered with fallout and similar radiation effects were noted. Seven months later the Japanese reported that one of the fishermen died of hepatitis. Parenthetically, hepatitis is a condition not directly attributed to radiation. These regrettable experiences demonstrated the need for larger warning areas. These have now been established during the operational periods and with continuing improvement in weather prediction, there is essentially no risk of hazardous amounts of fallout outside of the control areas.

The radioactive particles which remain in the atmosphere for long periods of time are carried by prevailing winds over a large area. These par-

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[1] Dunning, G. M.: Effects of Nuclear Weapons Testing, Scientific Monthly, 81: 265 (Dec.) 1955.

* I-131 uptake in the thyroid of humans and animals provides a sensitive index of radioactive fallout (Van Middlesworth, L. Radioactivity in Thyroid Glands Following Nuclear Weapons Test, Science 123: 982, 1956).

ticles may be inhaled, and if they find their way into water and food supplies they may be ingested.

A certain portion of this ingested or inhaled radioactivity is short-lived, whereas some is of long duration; some is excreted, while some lodges in particular organs and may remain over the lifetime of the individual. Fortunately the latter is rare with fission products as compared, for example, to radium or thorium.

To summarize a large number of available studies on the ingestion and inhalation problem, and with particular reference to the representative fission isotopes of strontium, iodine and carbon, Dunning[1] has calculated that the maximum personal accumulation from ingestion or inhalation in any given individual over 100 years of tests would still not equal the present permissible body burden of these radioactive materials. This calculation presumes a stable fallout at present levels. It is important to emphasize that careful and complete measurements are continuously being made by trained individuals to assure that the radiation exposure after nuclear weapons testing remains within biologically acceptable limits.

Finally, what does all this add up to? If there is no clear and present danger, how about cumulative effects? In short, what about chronic effects of radiation, and what is the risk of genetic damage by radiation to reproductive tissues? There is no argument that radiation causes irreversible, inheritable changes in the germ cells (mutations). Most of these mutations are considered harmful, and some may result in dead or defective offspring, not noticeable for a number of generations.

It has been estimated[1] that the average radiation exposure to us from all nuclear detonations to date is 1/10r. Seven roentgens might be expected from natural sources in an adult lifetime. The average general increase is then about 1/70 and, if the present testing program persists into the future, the increase in mutation rate due to nuclear testing would be in the order of 2%.

This is not negligible, but Dr. H. J. Muller, who discovered the effects of radioactivity on heredity, has this to say about the relative risks: "the genetic danger of the tests themselves is probably not as great as the genetic danger of incautiously administered x-rays. And there I would classify the great majority of medical administrations of x-rays at the present day."[2]

There are several types of "incautiously administered x-rays" in medical practice. One involves x-radiation administered to the abdominal area without shielding of the reproductive organs. Another would be the use of x-radiation in children where such x-ray is not strictly indicated. The latter has been cited in several studies[3] as having something to do with an increased incidence of cancer in the irradiated patients.

Some of the changes after x-radiation are not as subtle as the hereditary alterations or as cataclysmic as radiation carcinogenesis. There is strong experimental evidence of general increased susceptibility to disease, premature aging and shortened life span with chronic exposure to radiation.

Summary

All x-rays are dangerous. Fallout is no exception. The bomb test program involves a calculated risk. I agree with Furth[4] that "there is a vast difference between a carefully prepared program for exploding nuclear devices at places and times chosen to minimize possible injury to man, and an all-out war where both sides use such devices in the most damaging ways possible . . . if the first alternative helps to prevent the second, we must accept the first, with the uncertainty of some information not yet known on possible radiation injuries to a small number of people."

[2] Muller, H. J.: What Will Radioactivity Do to Our Children? U. S. News and World Report—pp. 72-78 (May 13) 1955.

[3] Editorial: Association of Irradiation with Neoplasia in Children and Adolescents. Ann. Int. Med. 44: 579 (Mar.) 1956.

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EFFECT OF RACE, DIET, AND CLIMATE ON CARDIOVASCULAR DISEASES

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Climate affects heart disease very little, and racial factors are hard to separate from others which are perhaps more important. Diet is important, but too little is yet known to justify our advising patients anything but moderation in this regard.

CLIMATE has very minimal effect on the heart because of its rapid adaptability. Subjects exposed to a hot and humid climate will temporarily increase their blood volume and even their venous pressure, but quickly return both to normal. Likewise, those being transferred to a cold climate for a very brief time decrease their blood volume, and rapidly return it to the previous baseline. Diseased and less elastic cardiovascular systems may more frequently develop complications like coronary thrombosis during extremely hot spells, for the incidence is higher at those times. Formerly it was felt that rheumatic fever was more prevalent in the cold and damp portions of the world, but studies now show the incidence to be directly related to the prevalence of the streptococcus. You may well remember in the 1930's when Paul White took his large group of rheumatics to Florida one winter in order to avoid the bleak New England weather, hoping to show a lower incidence of reactivation of rheumatic infection. The experiment in climate was terminated and never repeated because of several deaths in the group from acute rheumatic fever while in the warm sunny South. I soon discovered in our war days that the streptococcus did not recognize the great state of Texas, and brought down soldiers there with rheumatic fever just as it did anywhere else. Of course, we now have penicillin prophylaxis and all of those figures need revision. We live in different world surroundings.



DR. LEVAN

Race

We are learning much about race and the heart. Statistics here, too, will need much revision and study. For instance, Bays and Scrimshaw *Circulation,* November, 1953, declared studies from all over the world show variable standards, poor cross section of population, and even discrepancies in their considerations of hypertension. The lower life expectancy in many of these countries due to starvation, infection, and accident leads to a statistically younger group's being compared to the more advanced races with their much higher percentage of old persons. Studies in isolated mission hospitals where the patient census is dominantly acute infection rather than of mixed etiology, or in a camp of robust laborers, surely isn't a study of the general population. The greatly different social and economic level varies the stress, the personality, and above all the diet of these peoples.

One cannot compare the Chinese laborer living on a few handfuls of rice with the well-fed Negro laborer, and base differences on ancestry. Chinese have been known to run lower pressure than inhabitants of the United States, but their average weight was considerably lower—a very important factor. Those who approached the American state of nutrition and body weight carried almost the same level of pressure as the Americans.

Reports on the blood pressure of the African negro are quite conflicting and the problem is unsettled at this time. African negros transplanted to Panama have a higher incidence of hypertension than the native Panamanian and whites, none of whom are characterized by obesity or undernutrition, and all of whom are subject to the same working conditions.

However, it must be concluded that all studies do point to the tendency for Puerto Ricans, Guatemalans, Mexicans, Panamanians, South Africans, Eskimos, and Chinese to run lower mean blood pressure, and to have less atherosclerosis than other people. Thus, while there appear to be racial differences in the incidence of hypertension and atherosclerosis, the importance of biologic, psychologic, and sociologic factors has not been evaluated.

Diet

Some progress has been made the last few years in regard to diet. After World War I there was

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evidence to indicate the depleted diet of the ravaged countries seemed to reduce the incidence of coronary atherosclerosis, while there was a return to the pre-war level soon after the diet of plenty was resumed. Again after World War II reports came out of Norway showing that during German occupation no dairy products, fowl, or fat were available. The incidence of coronary disease and atherosclerosis fell to a very low level at that time, only to return to its former level after the German withdrawal and the return of the dairy herds and fats to their owners. Incidentally, as in other statistics under similar circumstances, infections, especially tuberculosis, showed a tremendous increase during the period of inadequate diet.

New studies on a world-wide basis were initiated soon after these facts were recognized. Here again rose the point concerning the great difference in incidence of atherosclerosis on a world-wide basis that could not be attributed alone to race, climate, or geography. Nor could atherosclerosis and hypertension be based alone on the tempo of living and mental stress. It was seen that atherosclerosis seemed to be lower in these peoples with a diet low in cholesterol and neutral fat.

The Japanese on a native diet, in over 10,000 autopsies, were seen to have serious atherosclerosis in only 1.7% of cases. In those on an American-type diet, the incidence rose sharply.

The same findings were reported on the Bantus of South Africa with a diet of only 10% or less of the calories in fat.

Keys cited the greatly different diet between the people of Bologna and those of Naples, Italy, with the same difference in incidence of atherosclerosis.

Of the soldiers killed in Korea between ages 18 and 26, 70% had a significant degree of coronary atherosclerosis; and the diet in the U. S. Army has 45% of its calories in fat. The Bostonian eats about 35% of his calories in fat and has a 12% coronary atherosclerosis rate, while in Minneapolis 45% of the calories are in fat with coronary sclerosis at autopsy in 26½%.

Figures like this would seem to point to diet as the problem in atherosclerosis. It would appear that man, in reaching his present higher stage of civilization, and the present luxury in diet—something he never attained in days gone by—has created a situation which his body chemistry has not developed a means of handling. He apparently cannot survive on this diet any better than he withstood the infection and stress, with malnutrition, that had been a constant problem through the ages.

On the other hand, the problem is more complex, since there is much individualism. We have all seen the octogenarian who has been eating ham, eggs, butter, and ice cream every meal and every day. As Howard Sprague points out, many people have eaten 100,000 eggs in a long life time without acquiring lethal atherosclerosis. Irvine Page, the distinguished president of the American Heart Association this year, said in his 1954 Lewis A. Connor Memorial Lecture: "Four years ago I studied the problem in myself, chiefly I think because my serum cholesterol was about 300 mg. and my 'abnormally' elevated Sf 10-20 lipoproteins were certainly two strikes against me. At first I reduced the fat content of my diet to about 15% of the total calories, making up the loss with carbohydrates. There ensued a sharp fall in plasma lipid, a sharp loss of body weight, an impairment of my disposition, and a contraction of my circle of friends. During this period of several months, gastrointestinal disturbance was marked, but worse was the feeling of depression and irritability. Addition of vegetable fat quickly overcame both but simultaneously raised the serum cholesterol and beta lipoprotein. I was unable to find any decisive influence of protein. The experiment was ended after a year, with a firm conviction that diets should be changed with the greatest caution and that physicians should be required to try their diets before prescribing them. Subsequently, I have for three years voluntarily kept my lipid intake approximately half the level of five years ago, and while this is effectively keeping my waistline down, it has no effect on blood lipids."

It is not only proper but important to mention here that very low fat diets, in which fats furnish below 15% of total calories, have been shown to cause fatty degeneration of kidneys and liver in animals. Thus, one may carry a restricted diet too far. Moderation at this time is therefore advised.

Dr. Paul White summarized the World Congress on atherosclerosis, saying "We are in an epidemic of coronary artery disease which is sweeping over the face of the earth and causing more deaths than any of the infectious epidemics, such as cholera or plague, known to the history of man. It would appear that this epidemic of coronary artery disease is the result of the attainments of civilization. This attainment of our civilization has been to have as rich a diet as possible and as little to do as possible."

May I suggest that, until we know more about diet and body chemistry, we advise our patients moderation, neither restricting them too greatly nor allowing them to go on with excesses. We should not restrict them to the point of making life miserable from a dietary standpoint, but we can advise them to steer a more moderate middle course, keeping the fat intake lower than customary and the body weight nearer average.

41 Oley St.

GENETIC IMPLICATIONS IN HEALTH AND DISEASE

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Medical genetics, though an infant science, has told us much about the origin of many diseases and will tell us more in the future. Genes, mutant genes and polygenes are becoming increasingly familiar and accessible to investigators, and genetics is coming closer and closer to the clinic and the bedside.

ALTHOUGH one of the youngest of the sciences, genetics has made spectacular progress over the past few decades, culminating in its recognition as a valuable and essential hand-maiden to medicine. The realization of the importance of the applications of medical genetics to health and disease is testified to by a recent survey indicating that instruction in this area is now provided in well over half of the medical schools of America.



DR. SNYDER

Genetic investigations have been made of several thousand deviations from normal health and well-being in man. For at least several hundred such aberrancies, simple genetic bases have been reasonably well established. The proof of a genetic basis for a trait involves precise and specialized techniques, and conclusions regarding a hereditary background for any disease or anomaly should be viewed with extreme caution unless such technical methods have been employed.

The basis for the transmission of an anomaly, or of susceptibility to an infectious disease, is the gene. Genes are complicated molecules of desoxyribose nucleic acid, bound up with the proteins of the chromosomes as highly polymerized nucleoproteins. Not only are many individual genes being identified in man, but their mode of action is yielding to biochemical and physiological investigation. The basic activity of a gene now appears to be the development and production of a particular substance which has a specific effect on the metabolism of the individual. In most if not all instances, the substance is an enzyme, and is responsible for the catalysis of a particular step in synthesis or in degradation.

Under the influence of enzymes and enzyme systems, the body chemistry of metabolism, growth and development proceeds with remarkable smoothness. The enzymes produced by normal genes are highly adapted by long ages of natural selection. In the presence of normal genes, the requisite enzymes are formed.

Occasionally, however, a normal gene is replaced by a molecule of slightly different structure: a mutant gene. Mutant genes arise by mutation, which is an inexact copying of the normal gene during its usual process of constructing an exact duplicate of itself during cell division. As a rule, the enzyme produced by a mutant gene shows a diminution or loss of activity in catalyzing the specific reaction that the unmutated gene accomplished. The mutant gene henceforth duplicates itself in its altered chemical form just as faithfully as the normal gene formerly copied itself in its original form, and thus may become incorporated into the available pool of genes.

Because they are integral parts of chromosomes, genes occur in pairs in the individual. If a person has one normal gene of a pair, and a mutated gene as the other member of the pair, thus being heterozygous, the normal gene will ordinarily produce enough enzyme to facilitate the reaction. When, however, an individual is homozygous for the mutant gene, having both members of the pair abnormal, the enzyme will not be produced. The result is an enzyme dysfunction, which may lead to a physiological or morphological aberration. Indeed, more and more deviations from normal health are proving attributable to enzyme dysfunctions.

Many of the resulting aberrations are striking and readily recognizable. Thus, a normal gene *G* produces a phosphatase responsible for one of the steps in converting glycogen to glucose. A mutant form of this gene, *g*, fails to produce the enzyme. Infants who inherit *g* from each parent, and are thus of the genotype *gg*, cannot make this conver-

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sion. Glycogen accumulates in the liver, kidneys and heart, and early death results. The disease is known as hepatosplenomegalia glycogenica, or glycogen disease. Very recently a related disease has been investigated and clarified, namely galactosemia, in which the galactose derived from lactose in milk is not converted to glucose-1-phosphate and so to glucose. The abnormal concentration of galactose is fatal to those infants who are homozygous for this mutant gene and who thus do not produce the requisite enzyme galactokinase.

Normal individuals produce an enzyme which converts homogentisic acid to aceto-acetic acid and on to carbon dioxide and water. Proof that the enzyme is the result of the presence of a normal gene is found in the fact that those individuals who inherit a mutant of this gene from both parents cannot oxidize homogentisic acid, and as a result are afflicted with alcaptonuria. Although often harmless, the disease is potentially a very severe one, sometimes progressing to diffuse degenerative arthritis.

Phenylketonuria is a condition involving mental retardation and often mental deficiency. Individuals suffering from this disease are generally blonde and blue-eyed. Because of the mental deficiency they are almost always institutionalized. The cause of the mental deficiency appears to be bound up with the accumulation of phenylalanine (one of the amino acids) and its derivatives phenylpyruvic acid and phenyllactic acid. Although normal individuals produce an enzyme which converts phenylalanine to tyrosine, sufferers from phenylketonuria do not, and their phenylalanine must take the deaminizing metabolic route through phenylpyruvic acid, some of which is excreted in the urine. All melanin in such individuals must be formed from the ingested tyrosine, which accounts for the reduced pigmentation.

Phenylketonuria is the result of a mutant gene which fails to produce the enzyme phenylalanine oxidase, an enzyme produced under the influence of the normal gene by normal persons.

Infantile amaurotic idiocy, or Tay-Sachs disease, is characterized by progressive blindness, paralysis, and dementia, resulting in early death. Sphingomyelin, which is oxidized by normal individuals, is not oxidized by the victims of this disorder. A recessive mutant gene which fails to produce the requisite oxidase is responsible for the disease.

Normal hemoglobin (hemoglobin A) is produced under the influence of a gene which has mutated at various times in various individuals, resulting in a series of multiple mutant alleles, each of which results in the formation of a defective form of hemoglobin. Currently more than a dozen kinds of defective hemoglobin are recognized, variously named hemoglobin C, hemoglobin D and so on. Each of the aberrant types, having a distinctive mobility, can be recognized by electrophoresis.

The gene involved is known as *Hb*, and the various mutant forms are indicated by superscripts. Thus Hb^{A} results in normal hemoglobin, Hb^{K} produces hemoglobin K, and so on. Many hitherto obscure anemias have been clarified by the genetic application of the electrophoresis studies. To date only hemoglobins C and S have been reported in homozygous state ($Hb^{C}\,Hb^{C}$ and $Hb^{S}\,Hb^{S}$). Those individuals who have only hemoglobin C show an enlarged spleen, mild anemia, and chest and abdominal pains. Those homozygous for hemoglobin S have typical sickle cell anemia, a very severe and usually fatal disease.

Combinations of normal hemoglobin and one of the aberrant forms ($Hb^{A}\,Hb^{D}$, $Hb^{A}\,Hb^{I}$) etc., are often asymptomatic, the normal hemoglobin present serving to carry out the necessary functions. Occasionally, however, as in those individuals who are $Hb^{A}\,Hb^{C}$, bone and joint pains may occur.

On the other hand, combinations of two abnormal hemoglobins result in symptoms. Not all combinations have as yet been reported, but anemias of varying severity have been found in those individuals whose genetic composition is $Hb^{C}\,Hb^{S}$, $Hb^{D}\,Hb^{S}$, and $Hb^{G}\,Hb^{S}$.

Another and different gene concerned with the development of hemoglobin is the gene Th^{N}. A mutant form of this gene, Th^{T}, retards the production of hemoglobin A. Heterozygous individuals, $Th^{N}\,Th^{T}$, have thalassemia minor, with a mild anemia. Homozygotes, $Th^{T}\,Th^{T}$ have thalassemia major (Cooley's anemia, Mediterranian anemia), a very severe disease with a short life expectancy. The Th^{T} gene does not result in any detectable electrophoretic abnormalities. It may be concerned with the availability of serum iron, as contrasted with the mutant forms of the *Hb* gene, which affect the arrangements of the atoms in the globin portion of the hemoglobin molecule.

Combinations of Th^{T} with the various mutant forms of *Hb* do, however, result in marked symptoms. The genotype $Th^{N}\,Th^{T}\,Hb^{A}\,Hb^{S}$, for example, produces microdrepanocytic disease. The genotype $Th^{N}\,Th^{T}\,Hb^{A}\,Hb^{E}$ has been reported, with symptoms like those in thalassemia major. The combination $Th^{N}\,Th^{T}\,Hb^{A}\,Hb^{C}$ results in an anemia resembling sickle cell disease.

Genetic analysis is resulting not only in the understanding of the formation of hemoglobin and of the diseases resulting from its defective development, but such analysis has greatly clarified the complicated picture of the clotting of blood. The formation of fibrin, once thought to be a fairly simple procedure from prothrombin

and fibrinogen, is known now to involve many steps, each of which may be blocked by a gene mutation. Thus various mutant genes result in hemophilia-like disease through the failure to form respectively anti-hemophilic globulin (AHG); plasma thromboplastin component (PTC, Christmas factor); plasma accelerator globulin (PAG, labile factor, factor V); serum prothrombin conversion accelerator (SPCA, stable factor, autoprothrombin, factor VII); plasma thromboplastic antecedent (PTA); fourth thromboplastic component; factor X; or the Hageman factor.

In addition, mutant genes may interfere with the production of fibrinogen, or with the normal platelet thromboplastic factors. The occurrence of mutations in the genes which normally lead to the production of these various enzymes and other proteins has made it possible to identify the various steps in the clotting reaction, although much remains to be learned before the sequence of events can be accurately delineated.

The cooperative work of physicians, biochemists and geneticists has resulted in the clarification of the foregoing deviations from normal health, and the list could be greatly extended if time and space permitted. Genetic methods have greatly extended physicians' comprehension of normal development and its aberrations.

Although the examples just cited have been striking and comparatively easy of recognition, other mutant genes result in aberrancies which are quantitative rather than qualitative, and are appreciable only when several or many genes of this nature act cumulatively. Thus variability in stature, intelligence, susceptibility and immunity are frequently dependent, insofar as their genetic basis is concerned, on multiple genes, called polygenes, with individually minute but cumulatively appreciable effects.

Since the major genes with readily discernible effects tend to be kept at low incidences by pressure of natural selection, because of the viability impairment usually associated with them, it follows that the genetically determined portion of the variability in the *commoner* pathologic and infectious conditions is dependent on the action of polygenes.

The physician is frequently called on for genetic counseling. A basic acquaintance with the principles of medical genetics is essential for such counseling, and each family must be considered individually. The textbook case is as conspicuous by its absence in pedigrees as it is in the medical clinic.

Other practical applications of medical genetics include the instituting of preventive measures against diseases and anomalies on genetic grounds, the implementation of diagnosis and treatment on the basis of genetic information, the medicolegal applications of the inheritance of the blood groups, and the solution and comprehension of the problems of maternal-fetal incompatibility. These I have discussed at length elsewhere.

Genes cannot operate in a vacuum, and we can hope to understand adequately the action of hereditary factors in the development of a deviation from normality only in the framework of the environment in which the factors attain expression. Medical studies which contribute no strictly genetic data may nevertheless be of profound genetic value if they indicate the correlation of geographic, climatic, socioeconomic and other variables with mortality from various diseases, and hence provide guidance in the understanding of environmental interactions, which is so essential in any genetic analysis.

A good example of the coordination of medical and genetic studies is furnished by the recent investigations on coronary artery disease, in which the cholesterol:uric acid:phospholipid ratio, which appears to be genetically determined, is correlated with environmental exigencies in separating a potential coronary heart disease group from the group less likely to be affected.

The detection of the superficially normal carriers of genes for various diseases and anomalies is proceeding rapidly under the newer genetic technics, and there are now nearly 40 important hereditary diseases in which genetic carriers can be recognized with varying degrees of reliability. These include the anemias due to abnormal hemoglobin formation, several of the hemorrhagic diatheses, and others. This line of investigation has obvious important practical applications, and is being vigorously prosecuted in many laboratories.

Thus the employment of genetic methods has added a new and valuable set of technics to the field of medicine. The incorporation of the genetic viewpoint into the thinking of physicians is essential to the reaching of full potential in service to patients.

In closing it should be pointed out that within very recent years remarkable progress has occured in the study of the genetics of viruses and bacteria. Genetic bases are known for variability in these organisms in virulence and in resistance to antibiotics. It would seem to be essential in dealing with infectious diseases to have some understanding not only of the genetics of the human host, but also of the genetics of the invading parasite.

ERYTHEMA INFECTIOSUM

Review, and Report of Two Cases

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SINCE the first description of erythema infectiosum by Tschamer in 1886,[1] eleven subsequent reports[3] have appeared in the American literature, each occasioned by an epidemic outbreak. Its characteristic appearance is so akin to the four common exanthems of childhood (scarlatina, rubeola, rubella and roseola) as to evoke the synonym, "Fifth Disease"[3]; yet it is omitted from standard pediatric textbooks and only four of the reports[14] have been published in pediatric journals.



DR. MOORE

Because erythema infectiosum may be unfamiliar to many physicians, the following case reports and brief review of clinical features are presented.

Erythema infectiosum (fifth disease) often goes undiagnosed because it occurs chiefly in infrequent epidemics and is omitted from many standard textbooks. Nevertheless, it is a characteristic and easily diagnosed exanthem.

Case Reports

CASE 1.—L.A., an 8 year old Filipino girl, was seen on January 21, 1956, at the Straub Clinic with a generalized rash of six days' duration. On January 15, with no preceding symptoms, she developed a rash on her face, shoulders and arms. The eruption on her trunk and arms faded overnight but her cheeks remained flushed and shiny. Two days later macular urticarial lesions reappeared on her arms and upper trunk, while the facial rash had spread in a butterfly pattern and faded centrally to leave a red irregular border. By the fourth day lesions were present on her buttocks, forearms and upper legs. During this period, she had no apparent fever and no symptoms other than mild pruritus at night.

On physical examination, she was found to have a temperature of 99.6 F. orally and a generalized rash, as illustrated in Figures 1 and 2. In the initial eruption sites (face, upper arms, chest), the lesions were coalescent, flat and had an iris or serpiginous pattern. More recently involved areas on the forearms and legs presented raised macules. Her axillae, flexor creases, palms and soles were not involved. The remainder of her physical findings were normal. Her white blood count was 7,100 with 51 per cent polys, 33 per cent lymphocytes, 2 per cent monocytes and 14 per cent eosinophiles. During the subsequent two days, her rash disappeared with no desquamation.

CASE 2.—R.M., a 6 year old Filipino–White Russian boy, a cousin of L.A., and living in the same household, was seen at the same time with an erythematous eruption of thirty-six hours' duration, and no other symptoms. There was a pink macular raised eruption over his face, trunk, arms and upper legs, the lesions of which measured 5 to 6 mm. in diameter. His temperature was 99.2 F. orally and physical examination was otherwise normal. A white blood count was 10,000 with 57 per cent polys, 42 per cent lymphocytes and 1 per cent eosinophiles. In view of the urticarial appearance of the eruption, he was treated with bromodiphenhydramine (Ambodryl) hydrochloride, 50 mg. three times a day. By January 23, his rash had vanished and it did not recur.

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[14] Zahorsky.[4] Herrick.[6] Smith.[8] Fox.[9]

Discussion

The clinical and laboratory descriptions of erythema infectiosum are well exemplified by these two children. The disease usually appears as a bright flush on both cheeks "as if they had just been slapped,"[12] with few prodromal or accompanying symptoms. Only four children have had temperature elevations over 100 F. orally.[5] Pruritus is occasionally present; coryza is rare.

Within twenty-four hours, the facial lesions have spread to assume the butterfly distribution characteristically seen in lupus erythematosus; within forty-eight hours the eruption appears on the arms and upper trunk to spread later to buttocks and legs. As the rash ages, it becomes coalescent and fades centrally to form multiple iris, large serpiginous, or "lace-like" lesions. There is usually no involvement of axillae, flexor surfaces, palms or soles.

Laboratory studies have disclosed no diagnostic features although most of the children have had a mild eosinophilia (3 to 14 per cent). Throat cultures have grown normal flora. Blood cultures have been sterile. During one outbreak[15] a virus was isolated which grew on chick embryo and gave a positive neutralization test with convalescent serum.

Transmission is felt to be via droplet, with the incubation period lying between six and fourteen days. While the disease usually occurs in children under 12 years of age, an occasional adult case has been reported during epidemics.[4] The eruption persists six to ten days and one attack seems to confer permanent immunity. There is no cross immunity with other exanthems.

Therapy is primarily symptomatic. The short duration of the eruption in R.M. following antihistamine therapy cannot be specifically attributed to this therapy but may have been a variant.

No complications have been described.

[15] Nassi, L.: Attempts to Demonstrate and Cultivate Virus of Megalerythema, Riv. Clin. Pediat. 44: 449, 1946. Cited by Phillips.[12]



Fig. 1. Eruption of erythema infectiosum (Case 1), showing confluent lesions of cheeks (butterfly area) and outer aspects of upper arms, and "lace-like" pattern of confluent annular lesions on upper chest, said to be characteristic of the disease. Note sparing of elbow flexure.

Summary

Erythema infectiosum is a benign, transient exanthem of childhood consisting of a generalized macular eruption of the cheeks, upper trunk and extensor extremities, associated with low-grade fever and lasting six to ten days.

1020 Kapiolani St.



WEBSTER BOYDEN, M.D.

The President's Page

At this period the daily headlines consist largely of political polls and predictions. Neither these nor international events, however, can blind us to the continuing daily reports of deaths on our highways. Soon to be made, as this is written, is the prediction of the number of traffic deaths which will occur over the Labor Day week end. These deaths, added to those of other long week ends, plus the deaths occurring every day of the year, make up a total of nearly 40,000. This is not a "grand" total—it is an "appalling carnage."

Studies are now being made of the "host" (driver), of the "etiologic agent" (automobile), and of the "environment" (roads, weather, traffic, police). Considerable progress has and is continuing to be made in the environmental factors. And although the automobiles are being made faster and more powerful, some safety features are being slowly and, it would seem, reluctantly added. However, when these are taken care of, we still have the human component of the triad, "the nut that holds the steering wheel," and until further control is gained here, traffic deaths will continue to be heavy.

When applying locally for a driver's license, and I believe this is true for the Territory, the applicant must pass a visual examination consisting of visual acuity, muscle balance, and a test for color blindness; also a "true or false" type of written test for knowledge of the traffic code. No criticism of this examination can be made except that it is insufficient. In addition there should be required a comprehensive history and a complete physical examination. Regarding the history, the Harvard studies indicate that the driver is "likely to be too youthful, or inadequately trained, or not very intelligent, or egocentric, aggressive, antisocial, and irresponsible."

Furthermore, a reexamination should be required at specified intervals, every five years or possibly oftener. The fallible human element can never be entirely controlled, but an examination as outlined would aid and I can think of nothing else that would be nearly as effective.

W. Boyden

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[EDITORIALS]

Radiogenic Mutation

Damage done to *individuals* by injudicious exposure to ionizing radiations, in doses within the heretofore accepted limits of safety, consists principally of the small but statistically significant increase in liability to certain forms of cancer, notably thyroid cancer and leukemia. Some of the evidence for this was reviewed editorially in our preceding issue.[1]

Damage done to an individual's *descendants*—to the human race, that is—by such exposure, when it occurs during the reproductive period of his or her life, consists of the increase of the normal human mutation rate. The effect of this may not be apparent for several generations to come, but we cannot on that account afford to ignore it.

B. J. Duffy, Jr., M.D., assistant professor of medicine and director of Isotope Laboratory, Georgetown University Hospital, discusses in an article in this issue the relationship of radioactive fallout to this problem, and concludes that it is far less important than that of "incautiously administered x-rays."

The recently released independent conclusions of the U. S. National Academy of Sciences[2] and the Medical Research Council of Great Britain[3] lend support to this view. They calculate the roentgens of irradiation to the gonads during the first 30 years of life as follows: from natural background radiation, 4.3r and 3r (American and British figures, respectively); from medical and dental x-rays, 3r and more than 0.67r respectively; from fallout radiation at the present level, 0.02-0.5r, and 0.26r. Both groups agreed that an increase of from 30 to 80r (minimum, 5 to 15r; maximum, 150r) would be required to double the present mutation rate.

Neither report is conclusive, and both reports emphasize the need for more research. Certainly nothing in either report offers cause for alarm; indeed, on the whole, they are rather reassuring.

The important thing is that they clearly emphasize something that has not even occurred to the average physician; namely, that the possibility of permanent genetic damage is inherent in every roentgen exposure of any portion of the body, and that such damage is *likely* to occur if the gonads lie near the treated area and *sure* to occur if they are inside it.

Pending the further exploration of this problem at the basic research level, the practicing physician will do well to irradiate the abdominal, pelvic and perineal areas, and any areas in children, only on the basis of stringent indications and with all due precaution to avoid irradiating the gonads.

OASI for Physicians?

The A.M.A. last December requested its constituent "state associations"—interpreted by Dr. Dickinson as including the District of Columbia but not, except by courtesy, Alaska or Hawaii—to poll their members on their views about inclusion of doctors under the Old Age and Survivors Insurance provisions of the Social Security Act. Particularly under scrutiny was the question of voluntary versus compulsory coverage.

[1] Radiogenic Cancer (editorial), HAWAII MED. J. 15: 556-557 (July-Aug.) 1956.
[2] Biologic Effects of Radiation, Science 123: 1157 (June 29) 1956.
[3] Hazards to Man of Nuclear and Allied Radiation (news summary), Science 124: 112 (July 20) 1956.

Massachusetts physicians voted 3,253 to 988 in favor of (presumably compulsory) inclusion of physicians under Social Security. In New York State 42 of 61 component societies favored compulsory coverage by a 2,100 to 1,700 ratio. Pennsylvania favored compulsory coverage (on the assumption that voluntary coverage would never be available) by the narrow margin of 3,680 to 3,362.

Thirty-six constituent associations voted against compulsory OASI coverage. Twenty-five showed support in varying degrees for voluntary coverage. Only Indiana opposed it outright. Nine states were neutral. Fifteen states are not heard from; nine of these do not plan to conduct a poll at all.

Dr. Dickinson concludes from these polls that American physicians probably oppose compulsory, and favor voluntary, OASI coverage. He is an astute statistician, even if he does think D.C. is a state association and Hawaii and Alaska are not, and we suspect his conclusions are sound.

Clergymen have been granted voluntary inclusion under OASI, so it does not seem impossible that the same consideration may be extended to physicians. Neither does it seem impossible (or even unlikely!) that, if voluntary coverage is accepted, it will soon be made compulsory. The burning question, we think—and it hasn't been asked—is "If you can't have voluntary coverage, will you oppose compulsory?"

Medical Research: A Mid-century Survey[1]

The stated purpose of this admirable book—"to stress the imperative significance of basic research in solution of outstanding medical problems"—is accomplished with what Dr. Windsor Cutting of Stanford aptly calls "surprising virtuosity." Volume I, titled American Medical Research in Principle and Practice, tells how and why this study (under the auspices of the American Foundation) was made; reviews medical research in the perspective of basic sciences concerned; outlines current trends and problems in medical and biological research; discusses research agencies of all sorts, both those conducting research and those financing and applying it; and describes the handling of its results and their application. Volume II (Unsolved Clinical Problems in Biological Perspective) reviews in detail the status and goals of research problems in nine fields: cancer, infertility, arteriosclerosis, hypertension, rheumatic syndromes, tuberculosis, virus diseases, alcoholism, and schizophrenia.

Fifteen years of work, and the services of 26 consultants, many of them Nobel laureates, have gone into this remarkable 1500-page compilation. The beautifully organized, lucid, readable essays amply justify the effort. Any physician, indeed, anyone with an interest in science, could not fail to be agreeably entertained as well as instructed by reading them. No one interested in research, nor any person engaged in health agency work or connected with medical teaching in any way, can afford to miss them.

This is a book to read, and re-read. It is a book to own.

[1] Lape, Esther Everett: Medical Research: a Mid-century Survey (2 vols.), Boston, Little, Brown and Company, 1955. Price, $15.

Give to the Community Chest

Honolulu's Red Feather Drive opens October 7 this year, to secure funds for the support of thirty—*thirty!*—Oahu welfare and similar agencies. No charitable fund drive is more economically conducted than this one; none is spread widely over the entire community; none is more deserving of your generous support. All but a few pennies of your dollar are divided among such agencies as the Y.M.C.A., the Y.W.C.A., the Boy Scouts, the Girl Scouts, Palama Settlement, the Mental Health Association, the Salvation Army, the Volunteer Service Bureau, St. Anthony's Home, the Susannah Wesley Home, the Legal Aid Society, the Child and Family Service, and nearly a score of lesser agencies.

Doctors are sometimes regrettably ready to feel that their charity practice absolves them of further responsibility to the community. It does not. If it did, they would be selling such services, and at too high a price. Many citizens donate valuable time and services in a community cause. To forego private support of welfare services on this account is to open the door wide for Socialism —not creeping but galloping.

No-one will dictate the amount of your contribution—but please note that it must be divided by thirty. A token gift, representing no more than half a day's income, reflects no credit on the donor or on the professional group to which he belongs, and does the Chest no real good. Make your donation a realistic one, amounting to at least as much *per agency* as you would give if they approached you individually. Give generously, and help put the Community Chest over the top in 1956!

The Unprepared Colon

Preoperative sterilization of the bowel by specific antibiotics has in recent years lowered the morbidity following open operations on the colon to a level that compares with that following other intra-abdominal procedures. These agents have become universally accepted, so much so, in fact, that surgeons trained in the antibiotic era have come to accept them as a sine qua non for opening the colon during laparotomy.

While no one will question the desirability of sterility of bowel contents when open operation on the colon is required, one must not infrequently choose between opening the unsterile colon and postponing definitive surgery until a week or ten days later. Every surgeon dislikes staged procedures and multiple operations, and when a single stage procedure can be carried out safely and "without appreciable increase in morbidity" this is obviously desirable.

The principles of bowel surgery have not changed basically since the advent of the antibiotics: mechanical cleansing of the bowel is still essential, and accurate anastomotic technique is as important as ever in achieving good final results. Protection of the wound and peritoneum against contact with bowel contents is still essential in avoiding the complications associated with infection. If one rigidly adheres to these principles, it is possible with the use of intraperitoneal antibiotics and postoperative parenteral antibiotic therapy to perform open operations upon the previously unprepared colon without fear of untoward complication.

Not infrequently in the course of pelvic surgery the operator finds that the disease process is primary in the colon, or involves the bowel wall or mesentery in such a manner that complete removal of the diseased tissue requires opening of the bowel or interfering with its blood supply so that resection is necessary. The same situation occurs in gastric surgery, and occasionally the "acute appendicitis" turns out to be cecal or sigmoid diverticulitis. It is naturally desirable to correct these lesions at the time of the initial exploration.

Experience has shown that if the colon is not obstructed proximal to the lesion, resection and primary intestinal anastomosis can be carried out safely without previous use of antibiotics. Of course it is desirable to have an empty, grossly clean colon, which condition exists if cleansing enemas have been utilized prior to laparotomy—as they should be in all elective procedures. Even this requirement is not essential, however, if proper precautions are taken by the operator to pack the operative field with abdominal pads and to prevent spillage from the proximal bowel. This latter can be done with rubber-shod intestinal clamps, or by passing a Penrose drain or rubber catheter through the mesentery adjacent to the bowel and tightening it as a tourniquet to prevent the escape of liquid stool from above. The liberal application of suspension of Neomycin to the completed anastomosis and adjacent viscera as recommended by Poth seems a logical and desirable safeguard. Copious lavage of the wound with saline solution with the closure of each layer floats out devitalized fat and bacteria, and should be carried out following the closing of the peritoneum. No drains are placed, and in our experience proximal decompression is unnecessary unless obstruction is present. Postoperative use of large doses of penicillin and streptomycin is routine and is undoubtedly largely responsible for the low incidence of wound infections and intraperitoneal infections seen in these patients.

JAMES W. CHERRY, M.D.

Book Reviewing

The goals and pitfalls of the reviewing of medical books are amusingly and informatively discussed by Dr. William B. Bean in the April, 1956 issue of the *A.M.A. Archives of Internal Medicine*, of which he has just become Book Review Editor. We recommend it heartily to all, and urgently to those who are willing to contribute to the Book Reviews section of this journal.

Dr. Bean disapproves of the anonymous book review, as we do: reviews in this department of the *Archives* will be signed from now on, as soon as the backlog of unsigned reviews is used up.

The pledge to which Dr. Bean commits his contributors is one of "fair, not punitive" criticism, thoughtfully and honestly expressed. He wants them "to avoid spraying mental D.D.T. as self-appointed purifiers." He warns book makers that he will wage war against references without titles—a highly commendable attitude.

Don't miss this article—especially if you're willing to be called on to write an occasional book review.

This is What's New!

"Can a mother have a child without the assistance of a father?" queried the British *Sunday Pictorial*. Nineteen English mothers presented themselves as proof that **parthenogenesis** in human beings was possible. London medical researchers then investigated these nineteen pairs of mothers and daughters. Two possible mechanisms of parthenogenesis were considered. (1) Budding from somatic cells of the mother, in which case, the mother and child would be identical twins, one generation apart. (2) Autofertilization, in which case, the mother and child would not necessarily be alike. Of the original nineteen, eleven were eliminated with preliminary interviews with a discussion of the facts of life. Of the remaining mothers and daughters, all but one pair were eliminated by exhaustive blood group studies. Mrs. Alpha and daughter defied elimination on the basis of any of the tests that were run. In fact, on the basis of the immunological studies, including blood types, there was less than one chance in one hundred that the daughter had a father. Small wonder that "there will always be an England." (*The Lancet* [June 30] 1956, page 1071.)

* * *

Prednisone and prednisolone in usual therapeutic dosages **depress thyroid function.** The maximal drop in protein-bound iodine concentration was reached about three or four weeks after the steroid therapy was started. There was also depression of the 24-hour radioiodine uptake, and some elevation of the serum cholesterol. The BMR was altered little. The cause of this depression appears to be inhibition by the cortical steroids of the pituitary production of the thyrotropic hormone. Thus far, there appears to be no clinical significance of these observations, however. (*J. Clin. Endocrinol. & Metabolism* [May] 1956.)

* * *

Eli Lilly and Company, which did much of the early work with insulin, has recently expanded its clinical investigation of **Carbutamide.** This sulfa derivative, which is taken by mouth, may be a **substitute for insulin** in the adult with mild diabetes. It has been suggested that it acts by inhibition of anti-insulin substances. Its toxicity is probably the same as that of other sulfonamides, with agranulocytosis high on the list of serious complications. Periodic white counts are recommended with discontinuation of the drug if leukopenia, especially if associated with an upper respiratory-like infection, occurs. (*The Lilly Research Laboratories* [July] 1956.)

Why is there no sarcoidosis in Hawaii? Dr. Michael reviews the epidemiology of sarcoidosis in the *Annals of Internal Medicine*. The chief foci of this disease are in the United States, especially in the southeastern area, the British Isles, Scandinavia, France, Germany and Switzerland. The incidence is the highest in the rural areas. It has been proposed that **beryllium** occurring in the soils of endemic areas may be responsible for the syndrome of sarcoidosis, even though beryllium is not found in patients with this picture. The presence or concentration of beryllium in the soils of Hawaii slips my mind at the moment, but this value may be important. (*Ann. Int. Med.* [July] 1956.)

* * *

A general practitioner from North Carolina discourses on the palliative treatment of the **constitutionally inadequate patient.** In the first sentence of the article, he puts the reader straight by stating that the topic is actually **"coping with crocks."** As the newest physician in the area, he soon found his office flooded with these patients, usually females between the ages of 20 and 50. He frankly observes that "since I was neither prepared nor permitted to operate upon them I had to learn to cope with them." A goodly number had already lost their tonsils, teeth and appendix at an early age, and at a somewhat later age had parted with some part of the reproductive system by some type of female operation, of the details of which she is often not quite certain. Her symptoms are multiple and usually have existed as long as she can remember. Her head aches, there are weird noises in her head, her heart beats too fast and she has smothering sensations, she coughs and on occasion has even coughed up blood, but knows very well that the chest x-ray does not show everything. She is bloated and either cannot eat a thing or cannot stop eating, and so it goes through the system review. She is sick, inadequate and dependent. The author urges that the American doctor proves a safer crutch than chiropractor, faith healer, hypnotic drugs and useless surgery. To the doctor undertaking this problem, he advises a positive continuous program and the free utilization of diet, exercise, harmless medications and conservation of the physician's and patient's time by not going overboard on vocal catharsis. (*Postgrad. Med.* [July] 1956.)

* * *

Two Brooklyn internists write on which **nodular goiters** should be removed. Part of the

(*Continued on page 72*)

Perhaps It's Your Nerves

HOSPITALIZATION OF THE MENTALLY ILL

The statutes covering the hospitalization of mentally ill people in Hawaii are unfamiliar to most physicians. The following brief summary of Hawaii's laws regarding reception of patients at the Territorial Hospital is offered for reference purposes:

(1) **Voluntary Admissions** (Section 4034, 1945)

Any person not under a criminal charge may request voluntary admission to the hospital. If he makes written request for discharge, he must be released within 15 days. (In the case of an alcoholic or a drug addict, the mandatory release does not apply.)

For practical and therapeutic reasons, only non-psychotics are admitted as voluntary cases. All patients are first interviewed by the Admitting Physician at the hospital and decision to admit is made at that time. It is best for referring physicians to call the Clinical Director of Territorial Hospital about prospective patients *before* they are sent.

(2) **Emergency Commitments** (Section 4022, 1945)

A. Any police or health officer or employee of the Territory or one of its counties may take into custody a person "apparently mentally ill," and confine him in the county detention ward. It is "the duty of any Government Physician" and lawful for any other licensed physician to examine the allegedly mentally ill person and recommend hospitalization or release. The person can be held only 48 hours in the detention ward without application for commitment to a judge or magistrate.

B. Section 4033. In case of an emergency requiring immediate hospitalization, the patient may be admitted upon a certificate signed by two licensed physicians. The certificate states their opinion that the patient needs immediate hospitalization. The family or any interested friend may apply for the admission. Patient may be retained by the hospital for 10 days on this paper. Admission may be refused if improper.

(3) **Regular Commitment** (Section 4015, 1945)

Step I: The family, a health or welfare officer or interested friend, may apply to a magistrate or judge for hospitalization.

Step II: Any licensed physician may examine and certify that in his opinion the person is mentally ill to a degree requiring hospitalization.

Step III: Notice may or may not be served upon persons depending upon their condition and a formal hearing with the patient present may or may not be held.

Step IV: The magistrate may order the person hospitalized at Territorial Hospital after reviewing the application and physician's certificate.

The regular commitment form is used in most cases. The Territorial Hospital staff does not participate in the preparation of physician's certificates for commitment. The blank forms are furnished by the Director of Institutions Office to judges, magistrates, and government physicians.

(4) **Special Commitments**

A. Section 4024. "Any person believing himself to be addicted to excessive use of drugs or liquor" may apply for an order of commitment. This application must be accompanied by a physician's certificate confirming the probable addiction. The magistrate or judge makes the decision for or against commitment. Any other family member or interested party may make the application for the alleged addicted person (or alcoholic).

B. Act 257, 1955. The Attorney General files with the Circuit Court a statement indicating the person is a drug user. The court orders two physicians to examine and report to the judge. The patient may have counsel. The court decides upon hospitalization. The patient is returned to the court upon discharge.

C. Section 4034. Persons addicted to alcohol or drugs may apply for voluntary admission to the hospital. If accepted, he must be under hospital jurisdiction for at least six months. Only well-motivated applicants are accepted on this basis.

D. Section 4033. Any eligible person may apply for hospitalization of an individual *who does not object* thereto. Such application must be accompanied by a confirming physician's certificate. This requires only notarization, not court action. Use of this form is discouraged since some patients are too confused to object.

Although our laws are fairly modern and offer help and protection to patients and community, there are still flaws. These problems seem to lie in procedures rather than the intent of the statutes. Commitment is often unnecessarily complicated, traumatic, and embarrassing to the patient and his family. Ways and means of smoothing it out can be developed by coordinated study and action which will attain the end result of providing treatment and care for people who need them.

ROBERT A. KIMMICH, M.D.

In Memoriam --- Doctors of Hawaii --- IV

This is the fourth instalment of In Memoriam—Doctors of Hawaii.

In the cases of many of these early doctors, information is very sketchy. Mrs. Robert Y. Katsuki, chairman of the committee which compiled these sketches, would be grateful to be informed of any errors, either of omission or commission.

Dr. McDougall

Dr. McDougall was a native of Argyle, Scotland.

He arrived in the Islands in 1850 and died at Makawao, Maui, on October 4, 1869.

James Wight

James Wight was born in India in 1814 of Scotch-Irish parentage. He received a liberal education at the University of Edinburgh, from which he graduated in 1836. At the age of 22 Dr. Wight went to Australia where he practiced medicine. However, his penchant was for business and after 13 years he abandoned the profession of medicine and migrated to Hawaii.

Settling in Kohala, Hawaii, in 1850, he opened a store and carried on business until 1884 when he sold out to S. G. Wilder. He became interested in sugar culture when the Kohala Plantation was started and owned quite an interest in the concern. He also established Halawa Plantation and conducted it for a number of years. Later he left the management to T. S. Kay together with his son-in-law, J. W. Atkins.

Dr. Wight was married to an Australian and had a large family.

From 1852 to 1863, when Kamehameha V ascended the throne, Dr. Wight held the position of Circuit Judge. Keenly interested in politics, he was elected representative in 1886 and was made a noble in 1887. In the House he was noted for his independent stand in those trying times.

Although Dr. Wight had no inclination to practice medicine, he was always ready to assist any sufferer needing the services of a physician.

Dr. Wight died September 2, 1905, at Kohala, at the age of 91.

Wesley Newcomb

Very little is known about Dr. Newcomb. He seems to have arrived in Honolulu about 1850 and to have left the Islands about 1855. He is best remembered for the part he played in the political life of 1853.

Dr. Newcomb was one of those cultured physicians who took an active interest in the sciences as well as medicine. He was a close friend of Dr. William Hillebrand. His stepdaughter, Anna Post, became Dr. Hillebrand's wife.

Dr. Newcomb was a member of the first Board of Health organized by order of Kamehameha III, by and with the advice of the Privy Council, on December 13, 1850. During the smallpox epidemic of 1853 he served as physician for one of the city divisions. He became so incensed over the manner in which smallpox vaccinations were forced on the people that he joined the Committee of Thirteen who in 1853 drove Dr. G. P. Judd from office.

The Newcomb home, with office in the rear, was on Beretania Street, opposite the Kaumakapili church.

During the doctor's residence here he became known as an authoritative Hawaiian conchologist.

Dr. Newcomb died on January 25, 1892, at Ithaca, New York, at 83.*

J. Herrick

Dr. J. Herrick died October 24, 1868, at South Kona, Hawaii, at the age of 72. He was a native of New York.

Ferdinand William Hutchison

Dr. Ferdinand William Hutchison, a Scotsman, was one of the most influential persons in Hawaii during the reign of Kamehameha V. He was a member of the Royal College of Surgeons of Edinburgh, Scotland. About 1860 he came to Hawaii and was a practicing physician in Honolulu when Kamehameha V came to the throne in 1863. One of His Majesty's first acts was to appoint Dr. Hutchison a court physician.

Dr. Hutchison succeeded Charles G. Hopkins as Minister of the Interior in 1865. In this capacity he built the Hawaiian Hotel and carried out many public building projects. As a member of the Board of Education he had great influence in determining new policies. As the personal physician of the king and a member of the Board of Health his advice was considered in the problems of segregating victims of leprosy, controlling epidemics, and other public health matters. It was Dr. Hutchison who, in 1865, selected Kalaupapa on Molokai as the place to isolate the lepers.

He was a member of The Queen's Hospital staff until 1882 and also served as port physician.

Mark Twain described Dr. Hutchison as having sandy hair, sandy mustache, sandy complexion. He says, "He is altogether one of the sandiest men I ever saw, so to speak: is a tall, stoop-shouldered, middle-aged, lowering-browed, intense-eyed, irascible man, and looks like he might have his little prejudices and partialities. He has got one good point, however—he doesn't talk."

At some unknown date, Dr. Hutchison moved to Sydney, Australia, and it was there he died on May 20, 1893, at the age of 74.

From "Tales About Hawaii" by Clarice B. Taylor.

C. H. T. Constantini

Dr. Costantini was a native of Berlin, Germany.

He died October 9, 1860, at Waimea, Hawaii, at the age of 57.

Luther Halsey Gulick

Luther Halsey Gulick was born in Honolulu, June 10, 1828, the son of the Rev. Peter J. and Fanny H. Gulick. His parents arrived in the Islands on March 30, 1828.

In 1840 he was sent to the United States to be educated. He attended the New York College of Physicians

* Most of the above material from a sketch by Mrs. Clarice B. Taylor.

and Surgeons and was graduated with his M.D. degree from New York University on March 9, 1850. On October 5, 1851, he was ordained in New York.

Dr. Gulick married Louisa Lewis on October 29, 1850, in New York City. They had eight children and one adopted child.

The Gulicks were pioneer missionaries for Micronesia. They sailed from Boston November 18, 1851, in the "Esther May," arriving in Honolulu March 28, 1852. They reached their destination, Ponape, on September 11, 1852.

On Ponape Dr. Gulick reduced the language to writing and prepared school books, hymn books, and translations of the Scriptures. They moved to Ebon in December of 1859.

In 1862 they came to Honolulu and visited the United States. On his return to Honolulu Dr. Gulick was appointed secretary to the Hawaiian Board. He was instrumental in reorganizing the churches after the withdrawal of the American Board.

Returning to the United States in 1870, Dr. Gulick served as one of the district secretaries of the American Board.

From 1871 to 1874 he went to Europe to inaugurate the mission of the American Board among Roman Catholic populations.

In 1874 back in the United States again, Dr. Gulick entered the service of the American Bible Society. He was appointed their agent in Japan and after completion of the translation of the Bible into the Japanese language he went to China. While in Japan Father and Mother Gulick, who made their home with him, observed their Golden Wedding anniversary on September 5, 1877.

In China he served as agent of the Bible Society in printing and distributing Scriptures. While living in Shanghai he also edited the *Chinese Recorder* and conducted services for the foreign residents.

In 1890 Dr. Gulick's health failed and he returned to the United States to his home with his son.

Dr. Gulick died April 8, 1891, at Springfield, Massachusetts, within a few months of his sixty-third birthday.

Charles Stewart Kittredge

Charles Stewart Kittredge was born January 6, 1833, at Nashua, New Hampshire.

He was a graduate of Yale and received his M.D. from the College of Physicians and Surgeons in 1863.

Coming to the Islands in 1864, Dr. Kittredge practiced in Honolulu and in Hilo. The Hawaiian Directory of 1880-1881 has him listed as physician, surgeon, and dentist as well as proprietor of a sanitarium in Hilo.

In 1887 Dr. Kittredge moved to Santa Barbara, California, where he spent the following ten years in practice. From there he went to Berkeley where he lived for eight years. After a short visit to Massachusetts, he returned to Santa Barbara in 1906.

On January 25, 1907, Dr. Kittredge died in Santa Barbara at the age of 74. He was survived by his wife, three married daughters, and a son, Dr. Maurice Kittredge.

He was a member of the Medical Society of California and of the Alameda County Medical Society.

Alexander Kennedy

Alexander Kennedy was born in the north of Ireland in 1818.

He came to the Islands first about 1860 from Pennsylvania by way of Cape Horn. However, he did not remain long, going from here to California.

About 1865 he returned to the Islands with the intention of starting a coffee plantation. Soon after his arrival he gave up this idea and practiced medicine. He had an office on Fort Street. After about one year he left.

In 1880 Dr. Kennedy returned a second time. During the smallpox epidemic he was engaged in vaccinating in the Koolau district.

He left for the United States in 1881 and from there he went back to his native Ireland, where he died at Cooleen House, Shandtown, Belfast, Ireland, on October 6, 1885.

The weekly edition of *The Pacific Commercial Advertiser* of November 24, 1885, states, "When a young man he studied for the ministry and took M.A. degree, but abandoned the idea, not having a good delivery."

John Strayer McGrew

John Strayer McGrew was born at Lancaster, Ohio, on December 23, 1825. He moved at an early age with his family to Cincinnati where his father founded the *Cincinnati Enquirer*.

He attended the Ohio public schools unitl he was 15 and then went to Oxford College from which he graduated. He received his medical training at the Ohio Medical College, Cincinnati, graduating in 1847.

During the Civil War, Dr. McGrew was among the first to volunteer. He served as a surgeon with the 83rd Ohio Regiment and was later promoted to staff surgeon of the U. S. Volunteers. He held the rank of lieutenant colonel under Generals McClellan, Sherman, and Grant. One of his appointments as army surgeon bears the signature of Abraham Lincoln.

At the close of the war, Dr. McGrew married Pauline Gillet at Washington, D. C., and the couple started on a world tour which brought them to Hawaii in 1866. Enchanted with the Islands, Dr. McGrew abandoned his tour and decided to enter medical practice in Honolulu.

For many years Dr. McGrew was in charge of the Marine Hospital.

He served as the first president of the Hawaiian Medical Society in 1892 and continued as president until 1897.

Dr. McGrew was a member of the commission which cooperated with Generals Alexander and Schofield in making a survey for an American naval base at Pearl Harbor, as provided for by the Reciprocity Treaty. He assisted in making plans for the coaling station and lived to see a portion of the harbor improvements completed.

He was called "Annexation" McGrew by King Kalakaua, who, although naturally enough opposed to Dr. McGrew's political program, often expressed his admiration for the doctor's sincerity and honesty of purpose. Dr. McGrew was an earnest advocate of annexation long before the Hawaiian monarchy was destroyed by revolution and not for an instant did he waver from his purpose.

Immediately after the overthrow of Queen Liliuokalani in 1893, Dr. McGrew was named by the "Annexation Club" as honorary editor of the *Hawaiian Star*. Selecting Walter G. Smith as acting editor, Dr. McGrew vigorously advocated the cause of annexation through the columns of the newspaper.

When annexation finally became an accomplished fact in 1898, five years after the revolution, Dr. McGrew was hailed as "The Father of Annexation."

Upon their arrival in Hawaii, Dr. and Mrs. McGrew became established in a homestead located on the present site of the Alexander Young Hotel. Their home became

(*Continued on page 74*)

Woman's Auxiliary

Delegate's Report

The fascinating and sometimes bizarre hats worn by the Mainland delegates at the thirty-third annual convention of the Woman's Auxiliary to the American Medical Association at Chicago last June really caught the eyes of the four Hawaii members who attended. We have seen such *papales* at fashion shows and in style magazines, but coming from a practically hatless community as we do, we had never realized that ladies really do wear these gorgeous creations.

The convention headquartered at the Conrad Hilton Hotel in Chicago, June 11 to 15. Eva Rose (Mrs. Clarence) Trexler and I were delegates, and Mary Ann (Mrs. Rodney) West was an alternate. We were sorry we had not known that Eleanor (Mrs. John) Cooper was going to be there, so that her credentials could have been submitted in time for her to be an alternate delegate as well. However, she attended all the meetings and social functions with us and represented Hawaii at a breakfast party given by the publishers of *Today's Health* for one member of each of the Auxiliaries which had led in securing subscriptions to the magazine. At a later general meeting, winners of the subscription contest were announced and we were proud that Honolulu County won a cash prize for third place among auxiliaries of comparable size.

The Hawaii delegation was in the limelight, as usual, because of our floral activities. Beautiful leis, each one different, were air mailed to us by our Auxiliary. At the first of the two lovely luncheons we attended, we were given the opportunity to present leis to each of the national officers and to the Auxiliary's Executive Secretary. They really created a sensation.

General meetings, and round table discussions conducted by national committee chairmen, were held and many fine ideas were presented. At the round table on organization and membership, the possibility of having pharmacists' and dentists' wives as Associate Members was suggested as a means of enlarging the membership in areas with but few doctors. However, there are many Auxiliaries with memberships smaller than the potential in our neighbor island counties.

There was great emphasis on fund-raising for the American Medical Education Foundation. The enthusiasm of Mrs. Frank Gastineau, the National Chairman who presided at this discussion, was inspiring. Her Indianapolis Auxiliary led all those in the country in AMEF contributions last year. Recently the Ford Foundation has agreed to match all AMEF contributions not earmarked for specific medical schools, up to $2,000,000 a year for five years—and perhaps longer. The total amount raised by Auxiliaries last year was $106,000. Some Auxiliaries contribute by raising their dues and donating a specified per capita amount, but most were in favor of good fund-raising projects as a means toward getting both money and improved public relations at the same time. Some novel ideas were presented which I am anxious to discuss with our Board.

A resolution was passed urging Auxiliary members to study the second Hoover Commission Report for more efficiency in our federal government, and to give support to its aims and objectives and to legislation to put them into effect.

It was suggested that Auxiliaries might assume responsibility for organizing and operating a health education booth at their local state fairs, under the name and auspices of the Medical Association, showing movies, preferably of cartoon type, and presenting appropriate exhibits.

It was also suggested that one or two joint meetings of the Medical Society and the Auxiliary be held each year, with a program of interest to both the doctors and their wives.

It was also suggested that Auxiliary members might act in a liaison capacity between the Auxiliary and various community organizations, to keep the Auxiliary informed of what projects are going on and also contribute to the latter.

It was a pleasure as well as a privilege to help represent Hawaii at this meeting. I was sorry to miss the final banquet. Ilka Chase was the guest speaker, but I was even more interested in seeing the climactic selection in General Chairman Mrs. Leonard J. Houda's series of spectacularly beautiful hats!

Mrs. Harry L. Arnold, Jr.
Delegate

Bureau of Medical Economics

Standard Health Insurance Forms

Are you using the Standard Health Insurance Form designed by your County Medical Society with the assistance of the local insurance industry? If not, you are causing unnecessary work for your office personnel.

The form was designed to cut down on office overhead and the training of new office personnel in using the hundreds of different insurance forms put out by the various insurance companies.

One doctor in the community is using the standard form for *every* commercial insurance claim, without exception. I have asked him to outline his procedure for your information and guidance:

✓ ✓ ✓

"It appeared ridiculous to me to receive a form partially completed by the patient and then to find that the information I was expected to give was in a large part a repetition of the information given by the patient. I determined that I would give only that information which I was legally entitled to give and which the patient, himself, was unable to supply. Therefore, I adopted the form devised by the Honolulu County Medical Society with the assistance of the local insurance firms and approved by the Hawaii Medical Association, insisting that all items except the diagnosis, the nature of any surgery, the charges and my signature must be completed by the patient and that the completed form be returned to the insurance company and not to the patient. This arrangement has proved most satisfactory. There was at first some protest by the companies against my stand but once it was learned that my stand was adamant, the difficulties ceased.

"I have been guided by the following legal, financial, and ethical principles:

1. No one is in a better position to fill out such items as: Name of insurance company, name of insured, name of insured's employer, et cetera, than the patient. My routine office records do not include the name of a patient's employer, and rather than have to contact a patient after treatment to discover this information, the patient submits it with the partially completed form.
2. The patient must give the physician permission in writing to divulge privileged information to the insurance company concerned. Should a physician divulge the presence of an obnoxious or loathsome condition to a third party without his written consent, the physician becomes liable to civil suit.
3. The patient should sign an assignment form, assigning benefits to the physician for services rendered. It is most disconcerting to treat a patient, dispense medication, fill out an insurance claim form, and then have the check sent to an unscrupulous patient who cashes the check and neglects to pay his just obligations.
4. The completed form is never returned to the patient. In some cases it is imperative, or requested by the family, that a diagnosis not be divulged to a patient, and if the form is returned to the patient, he has access to information which is not desired. If the written information is to be withheld from some, it must be withheld from all. As an aside to this principle, it was of great interest to me to note that in the report of the Council on Industrial Health of the American Medical Association, in the *Journal of the A.M.A.* 161:10, July 7, 1956, page 977, it is stated that, '. . . the confidential character of health examination records should be rigidly observed and access should be granted only on written consent of the worker, preferably after preliminary discussion with the examining physician.'
5. Irrelevant, inconsequential, and repetitive information should not be the concern of the physician. The offenders in this category are apparent on most any commercial form you pick up.

"It is a paradoxical curiosity that insurance companies send a check (generally for $3.00) to a physician for requesting information on the patient's medical history of an applicant for life insurance, yet presume that a physician will gratuitously complete a voluminous statistics-germinating set of papers. *The insidious presumption that the physician is a gratuitous employee of an insurance company must be thwarted soon or the presumption will become actuality.*"

✓ ✓ ✓

Although you may not agree with all of this doctor's methods, there is one thing I would like to emphasize. He uses the Standard Insurance Form for *every* claim on a commercial carrier *and they accept it.*

Here is the procedure you should follow:

1. Use the Standard Form in every case.
2. If a patient brings in a form for you to fill out, just fill in the Standard Form and attach the patient's form to it.
3. Don't let any insurance company tell you they will not accept the Standard Form. Legally they cannot refuse to honor it.
4. If you do use the commercial insurance company's form at their insistence, then a fee is in order.

R. M. KENNEDY
Executive Secretary

The Honolulu County Medical Library

MRS. ETHEL HILL, *Librarian*
MRS. MARY JO MURRAY, *Library Assistant*
Phone 6-5370

8:00 a.m.-4:30 p.m., and 7:30 p.m.-9:30 p.m.
Monday through Friday

Closed Saturdays at noon and Sundays

Closed all day and evening on National holidays and at noon on Territorial holidays

Recent Acquisitions

Biochemistry

Lillie, R. D. *Histopathologic technic and practical histochemistry.* c1954.

Wolstenholme, G. E. W., ed. *Ciba Foundation symposium . . . on histamine.* 1956. (gift of Ciba Foundation)

Cardiovascular System

Diggs, L. W. *The morphology of human blood cells.* c1956. (gift of publisher)

Keys, Ancil, ed. *Arteriosclerosis: a symposium.* 1955. (gift of publisher)

Lyon, Ernest *Virus diseases and the cardiovascular system.* c1956. (gift of publisher)

Clinical Medicine

Dock, William, ed. *Advances in internal medicine . . .* v.8. 1956.

Major, R. H. *Physical diagnosis.* 5th ed. c1956. (gift of publisher)

Page, I. H. *Hypertension.* 2d ed. c1956. (gift of publisher)

Dermatology

Schmidt, F. R. *Clinical selections in dermatology and mycology.* c1956. (gift of publisher)

Gynecology and Obstetrics

Corscaden, J. A. *Gynecologic cancer.* 2d ed. c1956.

Dennen, E. H. *Forceps deliveries.* c1955. (gift of publisher)

Fluhmann, C. F. *The management of menstrual disorders.* c1956. (gift of publisher)

Neurology and Psychiatry

Association for Research in Nervous and Mental Diseases *Neurology and psychiatry in childhood.* v.34. c1956.

Cantor, A. J., ed. *Psychosomatic aspects of surgery.* c1956. (gift of publisher)

Cholden, Louis, ed. *Proceedings of the round table on lysergic acid diethylamide and mescaline in experimental psychiatry.* c1956. (gift of publisher)

Cooper, I. S. *The neurosurgical alleviation of parkinsonism.* c1956. (gift of publisher)

Fromm-Reichmann, Nieda, ed. *Progress in psychotherapy, 1956.* c1956. (gift of publisher)

Laughlin, H. P. *The neuroses in clinical practice.* c1956. (gift of publisher)

Parker, H. L. *Clinical studies in neurology.* c1956. (gift of publisher)

Sechehaye, Marguerite *A new psychotherapy in schizophrenia.* c1956. (gift of publisher)

Winslow, Walker *The Menninger story.* c1956. (gift of publisher)

Nursing

Cowan, M. C., ed. *The yearbook of modern nursing, 1956.* c1956. (from Nurses' Association)

Ophthalmology

Callahan, Alston *Surgery of the eye—diseases.* c1956. (gift of publisher)

Pirie, Antoinette *Biochemistry of the eye.* 1956. (gift of publisher)

Pharmacology and Therapeutics

A.M.A. Council on Pharmacy and Chemistry *New and non-official remedies. 1956.* (gift of publisher)

Deichmann, W. B. *Signs, symptoms and treatment of certain acute intoxications.* c1955.

Marler, E. E. J., comp. *Pharmacological and chemical synonyms.* 1956.

Surgery

Sadove, M. S. *The recovery room.* c1956. (gift of publisher)

Urology

Cordonnier, J. J. *Clinical urology for general practice.* c1956. (gift of publisher)

Lowsley, O. S. *Clinical urology.* 2v. 3rd ed. c1956. (gift of Dr. deHay and Dr. Morgan)

Miscellaneous

Adriani, John *Techniques and procedures of anesthesia.* 2d ed. c1956. (gift of publisher)

Alvarez, W. C. *Medical writing.* c1955. (gift of publisher)

American Medical Directory. 19th ed. 1956, c1956.

Armed Forces Medical Library Catalog. 1950-54. 6v. 1955.

* * *

Mrs. Hill attended the annual meeting of the Medical Library Association, which was held in Los Angeles the week of June 18. The program was an excellent one and an exceptionally large number of librarians were registered from all over the world. Among them was Mr. Folke Strom from Göteborg, Sweden, who has been most kind in helping us build our Acta files through the Exchange.

An interesting day was spent at UCLA, where several members of the Atomic Energy Project presented an entertaining and informative panel on the application of atomic energy to biological problems. Later on, the new Medical Center and the Biomedical Library were visited.

After the convention, several of the librarians flew down to Mexico City and spent two weeks touring the countryside. At the impressive University City the medical school was in full swing and the stunning Library was admired. It was evident from the building which is going on throughout the entire country that great progress is being made.

Upon returning to the States, we drove north along the Pacific Coast. In Portland we had an enjoyable visit with Bertha Hallam and looked in on the Veterans Administration Hospital Library there.

Book Reviews

The Management of Menstrual Disorders.

By C. Frederic Fluhmann, M.D., 350 pp., illus., Price $8.50, W. B. Saunders Co., 1956.

In spite of his avowed objective to shed more light on the solution to the ancient problems of abnormal uterine bleeding, the Professor loses his bearings and presents instead: (1) a short analysis of hypothalamic-hypophyseal-thyroid-adrenal-ovarian endocrinology; (2) a review of normal and deranged menstrual physiology; (3) an outline of standard corrective measures, with emphasis on organotherapy; and (4) a list of currently available gonadal hormone preparations.

Such a circumferential peregrination is not unexpected. Many another medical author has taken pen in hand, mounted his trusty hobby horse, and sallied forth to subdue this gory monster and rescue the ladies in distress, only to find himself similarly boxed-up in the hinterlands, a full forty leagues away from the dragon—and the fair damsels. Nevertheless, the effort is well-intended and so if it profits the reader nothing more, he will be definitely intrigued by the section on the history of the concepts of menstruation and enlightened by the definitions employed as mileposts on this excursion into a challenging clinical field.

Suggested as a central medical library reference work only.

LYLE BACHMAN, M.D.

The Lung as a Mirror of Systemic Disease.

Eli H. Rubin, M.D., 288 pp., illus., Price $12.50, Chas. C. Thomas, 1956.

This is a good new reference book to consult in the next case of diffuse pulmonary disease encountered. It also may be helpful in differential diagnosis of a case of obscure fever or general symptoms in which there is an associated pulmonary lesion. These multiple diagnostic considerations are becoming more important each year as new cases of pulmonary tuberculosis become fewer. Consideration is given to the history and physical examination as well as to the x-ray. Discussion of laboratory aids is brought up-to-date and concluded with a consideration of prescalene lymph node biopsy and lung biopsy by the Klassen technique. X-ray reproductions, of average text book quality.

S. E. DOOLITTLE, M.D.

Surgery of the Eyes: Diseases.

By Alston Callaham, M.D., 447 pp., illus., Price $25.00, Charles C. Thomas, Publisher. 1956.

The author has written one of the most concise, clear textbooks on ocular surgery published. His illustrations are very well drawn and one is not lost following the individual steps in the various operations.

The chapters on lid surgery contain the author's own technique and all of them are well worth following in our own cases. The remaining chapters on cornea, lacrimal system, cataract surgery, glaucoma surgery contain many helpful points to everyone.

I have the highest praise for this book and no criticisms.

HERBERT G. PANG, M.D.

Hypertension.

By Irvine H. Page, M.D., Second Edition, 109 pp., Price $3.00, Charles C. Thomas, 1956.

This small (109 pages) handbook is for the somewhat literate patient who has, or is interested in, hypertension. It is admirably done. The language is as simple as consistent with clarity, the style is pleasant and readable and the advice and explanations lucid.

On controversial subjects, he gives the views of both sides and suggests a middle course. He avoids alarming statements insofar as possible. His exposition of the self-administered psychotherapeutic principles so valuable to a large percentage of such patients is admirable.

I have enjoyed reading it.

H. L. ARNOLD, SR., M.D.

A Synopsis of Contemporary Psychiatry.

By George A. Ulett, M.D., and D. Wells Goodrich, M.D., 243 pp., Price $5.25; C. V. Mosby Company, 1956.

This handbook is an up-to-date, well-written, and readable volume, presented from an eclectic point of view. It contains much useful information on psychiatric examination and treatments, neurological and psychological examinations, evaluation of the newer drug therapies, and psychiatric management of civilian disasters. A minimum of psychiatric theory is given, although there is a brief sketch of the contributions of the various schools of thought.

The reviewer agrees with the authors in most details although he feels, for example, that the section on involutional melancholia could have differentiated more clearly involutional psychotic disorders from disorders of the climacteric. This volume might well be read with profit by all practicing physicians and should help them greatly in evaluating and managing psychiatric disturbances.

RICHARD D. KEPNER, M.D.

Clinical Urology for General Practice.

By Justin J. Cordonnier, M.D., 252 pp., Price $6.75, C. V. Mosby Co., 1956.

This book was written primarily for the general practitioner and is based on the urology course given senior students at Washington University. Therefore, the material is limited to common urologic conditions, both surgical and non-surgical, with a brief explanation of the pathologic physiology involved and necessary steps in diagnosis and treatment. Detailed discussion of operative treatment is omitted, resulting in a short, concise, and readable text. There is a good chapter outlining the steps essential to complete urologic examination and it is recommended that all physicians follow such a procedure, omitting only the ultimate step of instrumentation, which should be left to the urologist. This book is an admirable text for the senior medical student and will be of great use to most general practitioners. The author is one of this country's outstanding urologists and the text is written in complete accord with all accepted and proved principles of present-day urologic practice.

WALTER S. STRODE, M.D.

(*Continued on page 72*)

HMSA—Its Place in the Community

The Membership

J. R. VELTMANN, *Executive Vice-President*

The final test of HMSA's real value as a community service rests with the satisfied member. It is gratifying to note in a study that nearly 50 individuals have maintained continuous membership in the plan since 1938. The growth of the plan from 670 members in May, 1939, to over 131,000 by the end of July, 1956, proves public acceptance and membership satisfaction of the Association.

One of the important factors which has made it possible for HMSA to operate as a low-cost plan is the sound underwriting requirements maintained constantly and a systematic method of perpetuating a high per cent of participation in the established groups. Let us briefly review the underwriting and enrollment practices.

1. *Group Members:*

When an employer indicates his interest in HMSA coverage for his company an HMSA representative calls on him to review the various plans available, the administrative and billing procedure, his responsibilities as a group, and to determine whether he plans to contribute towards the monthly dues for his employees. He is also requested to provide sufficient time for a group meeting of his employees for a thorough review of benefits, limitations of the plan, claim procedures and administrative procedures.

Immediately following the group meeting employees complete their HMSA application forms to determine the per cent of participation. The plan does not become effective until at least 75% of the total employees have enrolled and coverage is not extended to dependents until at least 50% of the married employees have enrolled their immediate families.

Once the group has been established a group leader (usually the accountant or personnel director) is designated as liaison officer between HMSA and the group. He is responsible for remittance to HMSA and conducts all business for the group. Monthly dues are handled as payroll deductions and remittance is made on a prepayment basis. An HMSA representative is assigned to service the group and all matters pertaining to the group are handled by him.

Semi-annual service periods are established for each group. The main purpose for such service period is to maintain a close check on the per cent of participation and to be sure that all new employees have been enrolled. Customarily, all new employees are privileged to become members within 30 days after becoming permanent employees. However, if they decline to join during this period, they must wait until the regular service period. This procedure acts as a control against adverse selection —the member's requesting membership only after he contemplates medical services or hospitalization.

2. *Group Conversion Members:*

When an employee terminates his employment the group leader indicates this on the monthly group billing. Upon receipt of this information HMSA immediately contacts the member and offers him continued membership on an individual basis. On this basis he is billed bi-monthly at his home address and pays his dues directly to HMSA. This service has been greatly appreciated by our members as the customary procedure of commercial plans is to cancel membership once you are no longer with a group.

Our non-group members have been an excellent source to bring in prospective groups. For example, when an HMSA member changes employment and discovers that his new place of employment does not have HMSA coverage he is generally interested in maintaining his group coverage. He is interested in establishing a group and takes the initial step of discussing the subject with his employer and fellow employees or he may request an HMSA representative to call on the employer to review the plan.

Members leaving Hawaii for the mainland may continue their coverage by transferring to the Blue Shield Plan of the state he plans to reside in. This is a privilege extended him through HMSA's participation in the Inter-Plan Transfer Agreement of the National Blue Shield program.

3. *Individual Enrollment:*

It is recognized that because of group enrollment requirements there is a segment of the community which is not eligible for such membership. Therefore, individual enrollment is made available twice a year for surgical-hospital protection. During these periods anyone under the age of 65 may join by completing a health statement which is subject to approval by the HMSA Medical Director. Such members are billed bi-monthly at their home address and dues are paid directly to HMSA.

From experience we find that proper servicing of members either through the group or individually has helped immeasurably to keep members satisfied. The assurance of continued membership regardless of their employment affiliation has made HMSA members recognize that they are an integral part of the Association, which is definitely in the community to serve them.

During the past four years, HMSA has realized an average net gain of 13,175 new members each year and during the first six months of 1956 there already has been an increase of 24,220 members, bringing the total membership in HMSA to over 25% of the total civilian population in the Territory of Hawaii. There are HMSA offices on each of the major islands to service properly our members—your patients.

County Society Reports

Hawaii

On July 5, 1956, the Hawaii County Medical Society held a dinner meeting at the Naniloa Hotel. There were sixteen members and six guests present. Guests were: Drs. Kolios, Isoda, Moonfell, and Chong, Dr. Walter Quisenberry, Executive Secretary of the Territorial Cancer Society, and Mr. Clyde Crawford, Executive Secretary of the Hawaii Chapter.

After dinner Dr. Quisenberry brought us a comprehensive and informative report from the National Cancer Society Meeting which pointed out recent developments in causes of cancer, notably the studies concerning virus as a factor in some types of cancer. A film on early diagnosis and treatment of lung cancer was shown. A brief session of questions and answers followed. One item brought up for discussion was whether the doctors felt there was a need for the Cancer Society to make dressings available to patients requiring them for a long duration. The matter was tabled.

The last business discussed was a letter from the Watumull Foundation to the Hawaii County Medical Society and to individual doctors opposing fluoridation of public drinking water. Dr. Mitchel, the president, felt that the Society should take a definite stand whether we favor fluoridation or not. After considerable discussion the Society voted to have the facts analyzed further and a definite stand be taken at a later date.

The meeting adjourned at 10:05 p.m.

* * *

The Hawaii County Medical Society meeting was held August 2, 1956, at 7:00 p.m. in the Hilo Memorial Staff Room with eighteen members present. Guests were: Dr. James Kent Luce from Parker Ranch; Dr. Robert Faus, Medical Advisor of HMSA, from Honolulu; Mr. Albert Yuen, HMSA statistician; Mr. James Carrol from the local HMSA office; and Mr. Yoshito Tanaka, Hawaii County Attorney.

Mr. Tanaka presented to the group the County's viewpoint on the free choice of doctors for workmen's compensation cases as far as county employees were concerned regarding Act 14, the amendment to workmen's compensation laws which became effective July 1, 1955. He asked the doctors' cooperation to check whether injuries that occurred during employment have been reported to their supervisors and, if not, to advise the patient to do so promptly.

Dr. Pete Okumoto, the Hawaii County physician, stated that all workmen's compensation claims come to his office for approval and asked that all doctors cooperate by being reasonable as far as fees for services were concerned.

Dr. Faus, Mr. Yuen, and Mr. Carrol presented the status of HMSA in respect to the per cent of utilization in the Blue Shield plan as a group and the community group medical plan. The percentage in the Blue Shield group was satisfactory locally as well as throughout the Territory. The utilization in the community group medical plan was satisfactory on all islands except Hawaii where some of the utilization went even higher than 135 per cent. After some discussion it was moved by Dr. Walter Loo, seconded by Dr. R. P. Wipperman, and passed unanimously that this Society continue the community group medical plan as status quo for another year.

The meeting adjourned at 9:30 p.m.

KAY K. OTA, M.D.
Secretary

Kauai

A special meeting of the Kauai County Medical Society was called to order on Tuesday, May 29, 1956, at 7:45 p.m. at Kauai Inn by the President.

Members present: Drs. Boyden, Brennecke, Cockett, Fujii, Goodhue, Ishii, Kim, Kuhlman, Kuhns, Masunaga, Wallis, Schilling.

Guests present: Drs. M. De Bakey and J. Felix.

The minutes of the regular May meeting were read and approved.

Dr. Fujii was appointed second alternate delegate to HMSA to replace Dr. Cockett in this position.

The meeting was adjourned to hear an address by Dr. De Bakey on gastro-duodenal ulceration.

* * *

The regular monthly meeting of the Kauai County Medical Society was called to order Tuesday, July 3, 1956, at 7:30 P.M. in the G. N. Wilcox Memorial Hospital library by the president.

Members present: Drs. Cockett, Fujii, Kuhlman, Masunaga, and Schilling.

The minutes of the special meeting held May 29 were read and approved.

Action on proposed amendment to the Constitution and By-Laws was deferred because two-thirds of membership required by Article IX were not present.

It was moved and seconded to pay the expenses of the May 29 dinner meeting from the treasury. Treasury to be reimbursed by billing each member for an equal share of the cost.

It was moved and seconded to send a letter of thanks to Mrs. Fujii, Mrs. Cockett, and Dr. Masunaga for their part in entertaining Dr. and Mrs. De Bakey.

It was moved and seconded to approve proposals of the Territorial Health Department regarding the use of federal funds for the purchase of polio vaccine.

Organization of committees for the coming Hawaii Medical Society meeting was discussed.

STANLEY SCHILLING, M.D.
Secretary

Maui

A special dinner meeting of the Maui County Medical Society was called by Dr. Fleming on June 22, 1956, at the Central Maui Memorial Hospital.

Members present were: Drs. Burden, Patterson, Underwood, Ferkany, Moran, Bergquist, Ohata, McArthur, Otsuka, Fleming, Wong, Kanda, Tofukuji, St. Sure, Kashiwa.

Guests present were: Drs. Boyd, Iaconnetti, Reichert, Good, R. C. Rucker and Mrs. Rucker.

Dr. Fleming called the meeting to order at 7:50 p.m.

Dr. Reichert, the Professor of Neurology at Stanford University Medical School, gave a very interesting lecture on head and neck injuries.

The business meeting was called to order at 9:00 p.m.

The minutes of the June 1, 1956, meeting were approved as circulated.

Payment to the Hawaii Medical Association in the amount of $729.00 was approved.

Report of the Board of Governors: Membership application of Dr. M. Boyd was presented to the members. It was moved by Dr. Burden and seconded by Dr. Patterson that the application of Dr. Boyd be returned to the applicant for completion as he did not have the endorsement of two doctors as required in the application. Passed unanimously.

Changes in the Amendments to the By-Law referring to a quorum: It was moved by Dr. Burden, seconded by Dr. Patterson, that the quorum consists of a majority of the active members of the Society.

Meeting adjourned at 9:50 p.m.

* * *

A special dinner meeting of the Maui County Medical Society was held on July 31, 1956, at the Central Maui Memorial Hospital.

Present were: Drs. Underwood, Sanders, Kashiwa, Tompkins, Izumi, Patterson, Moran, Otsuka, Ohata, Wong, Kanda, H. Kushi, Burden, Tong, Haywood, Ferkany, McArthur, Tofukuji, Fleming, St. Sure.

Guests present were: Drs. Haff, Boyd, Iaconetti, Smith, Faus, Mr. Albert Yuen and Mrs. W. O. Smith.

The meeting was called to order by Dr. J. Ferkany at 7:30 p.m.

He introduced the members of the HMSA that came to meet with us, Dr. Robert Faus, Mr. A. Yuen, and Mrs. W. O. Smith, Maui Representative of the HMSA. Mr. Yuen brought us an up-to-date report on the HMSA Community Group Medical Plan. He showed by graphic charts that Maui medical hospitalization was higher than the other islands. In order to meet the cost of the HMSA benefits he suggested the following solutions: 1) Raise the dues; 2) Lower the benefits; 3) Extend the present coverage for a longer period of time for further study. Dr. Patterson moved that we continue the Community Medical plan for another year in the County of Maui as is. Seconded by Dr. Underwood. Motion carried.

Dr. Patterson, Program Chairman, announced the program for the August 14 meeting, a discussion with Dr. Dorothy Kemp of the Board of Health, Medical Legislation on: (1) Medical care of indigents on a fee-for-service basis, (2) Abolishment of government physician positions on Maui, and (3) Creation of the position of coroner physician for Maui.

Dr. Fleming introduced Dr. K. O. Smith, who will be associated with Dr. Iaconetti at the Pioneer Mill Company Hospital.

Business Meeting. Minutes of the previous meeting were approved as circulated. Bills approved were: Duco Liquor Store $11.22, Honolulu Medical Society $11.20, Dr. Fleming $4.00, Secretary—Stamps and Postal Cards $25.00. Motion approved by Dr. Ferkany, seconded by Dr. Patterson.

Meeting adjourned at 9:35 p.m.

MAMORU TOFUKUJI, M.D.
Secretary

Honolulu

A special membership meeting of the Honolulu County Medical Society was held Tuesday, August 21, 1956, at 7:30 P.M. in the Mabel Smyth Auditorium. Dr. J. M. Felix presided and approximately 138 members were present.

Dr. Felix initiated the meeting by briefly reviewing the background of events preceding this special meeting. The special report of the Medical Care Plans Committee that was sent by mail to all members is reprinted, in part below. Asterisks mark deletion.

Medical Care Plans Committee Report

The Medical Care Plans Committee, appointed at a special meeting of the Honolulu County Medical Society, February 21, 1956, had as its original objective, ". . . To invite testimony from all interested parties, to reevaluate the entire structure of the HMSA and its present policies, as they may affect the future practice of medicine in the community, and ultimately to report to the Society its findings with mature recommendation for proper action."

Your Committee has met 25 times with 27 physicians, 2 members of the insurance industry, 2 representatives of organized labor, 1 member of the business community and 3 representatives of the HMSA.

It is apparent from the information obtained by your Committee that the vast majority of the members of this Society are in favor of the fundamental principles of the Blue Shield plans as exemplified by the HMSA. There is no doubt that the Blue Shield plans in general have been leaders in the field of medical insurance. The Committee feels that HMSA has served a valuable function up to now and has carried out the recommendations of the vast percentage of the members of the Medical Society. We find no objection to the management of HMSA that cannot be explained on the basis of:

a. Administrative enthusiasms in sustaining a program supported by the majority of the members of our Medical Society.
b. Lack of proper control on the part of the Medical Society.

In fact the administration is to be congratulated on their organizational skill and efficiency and the Medical Committee on their time, interest, and contribution.

Recommendation:

Your Committee, recognizing that the continued growth and development of voluntary Health Insurance plans is and will continue to be a major bulwark against the spread of closed panel and socialized medicine, recommends that this Society continue its association with the HMSA and also give its support to any voluntary Health Insurance programs fulfilling the requirements that will be outlined later in this report.

HMSA Board of Directors

From questions 5 and 6 of the questionnaire and also from individual testimony, it is apparent that some members of this Society do not think that the Society has adequate representation on the Board of Directors of the HMSA.

On questioning the individuals who advocated increasing the present number of physician directors (9) to equal or greater representation than the lay directors (13), it was found that this desire was motivated by fear of future events rather than dissatisfaction with past performance.

It has been repeatedly emphasized to your Committee that the Board of Directors of the HMSA has never

(*Continued on page 78*)

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AGRONOMY

Notes and News

This column is written for your information and entertainment about your professional, scientific and social accomplishments. If you have any newsworthy items, kindly phone the News Editor, Dr. W. J. Holmes, or his secretary at 6-2105 or mail them to 280 Young Hotel Building.

Personals

New Physicians

Dr. Phillip Watt announces the opening of his office in the Professional Center Building. Dr. Watt is a graduate of Creighton Medical School. He interned at Queen's Hospital and completed his residency in pediatrics at the Queen of Angels Hospital in Los Angeles.

Dr. Robert Rigler joined the x-ray department of the Straub Clinic. Dr. Rigler is a graduate of the University of Iowa. He interned and served his residency in radiology at the John Gaston Memorial Hospital at Memphis, Tennessee. He is certified by the American Board of Radiology.

Dr. Frederick B. Warshauer, formerly plantation physician for the Hawaiian Pineapple Company in Lanai City, joined the Fronk Clinic in their Kahuku office.

Dr. Ralph M. Beddow, formerly Chief Resident in internal medicine at Queen's Hospital also joined the Fronk Clinic.

Dr. Leabert Fernandez announces the opening of his office at 1541 South Beretania Street with practice limited to plastic and reconstructive surgery. Dr. Fernandez spent several years at the Huntington Memorial Hospital in Pasadena with Dr. G. V. Webster, plastic surgeon, prior to returning to Honolulu.

Dr. H. James Lambert also joined the Straub Clinic. Previous to returning to Hawaii, Dr. Lambert had completed a surgical residency at the University Hospital and ob-gyn residency at the Presbyterian and Women's Hospital in New York.

Dr. Kenneth Henry Rusch returned to Hawaii after spending two years as clinical instructor at the Neuro-Psychiatric Institute at the University of Michigan. Dr. Rusch is associated in the practice of psychiatry with Dr. Richard Kepner, with offices at the Alexander Young Building.

Dr. John M. Ohtani returned to Honolulu and announces the opening of his office, with practice limited to obstetrics and gynecology, at the Professional Center Building.

Dr. George Nip announces the removal of his offices to the King Kalakaua Building.

Dr. Robert Bell, formerly of the Kahuku Hospital, is now in Hilo, Hawaii, substituting for Dr. Sam Brown.

The following list of physicians moved into the Professional Center Building at 1481 South King Street: **Drs. Richard K. C. Chang, Yen Pui Chang, Bernard Fong, Thomas F. Fujiwara, Howard H. Honda, Edmund L. Lee, Francis K. Lum, Masato Ohtani, Perry Sumida, Isami Umaki, Elizabeth Y. Y. Wang, Goonzo Yamashita,** and **Vernon Jim.**

Dr. Thomas Mossman is at the Oahu Sugar Plantation assisting **Dr. Caldwell** during **Dr. Harold Chandler's** absence.

Dr. Robert Worth, a former resident of Shanghai, is now serving as resident physician at Kalaupapa Settlement. Dr. Worth is a graduate of the University of California Medical School. Prior to coming to Hawaii, he was on the staff of the South Pacific Hospital in San Francisco.

Dr. Serge G. Ross has been appointed by Castle & Cooke, Ltd. to serve as rotating plantation physician.

Dr. Edward V. Avakian returned to Hawaii and assumed the duties of senior plantation physician for Hawaiian Pineapple Company on Lanai.

Dr. Harold R. McKeen has been appointed assistant medical director of the Waialua Agricultural Company. Dr. McKeen is a native of Denver and is a graduate of Harvard University Medical School.

Dr. James K. Luce has taken over the duties of **Dr. Gardner Black,** retired, as physician for the Parker Ranch at Kamuela.

Dr. Irvine McQuarrie, formerly head of the Department of Pediatrics at the University of Minnesota, is now Director of Education at the Kauikeolani Children's Hospital.

Dr. Elizabeth Johnson announces the opening of her office at Dr. Cecil Saunders' former office in the King Kalakaua Building. Dr. Johnson is a graduate of University of Tennessee. She interned at Queen's Hospital, Honolulu.

Dr. William C. Wilson announces his association with Drs. Bell and Bell. Dr. Wilson is a former intern of Queen's Hospital.

Dr. Allan C. Oglesby returned to Honolulu to join the pediatrics department of the Medical Group. Dr. Oglesby is a graduate of the Medical College of Virginia. He interned at Charity Hospital, New Orleans. He has had residency training in pediatrics at the Children's Hospital in Honolulu and the Tulane Charity Hospital in New Orleans, Louisiana.

In the Service . . .

Dr. Philip Lee has been assigned to the staff of Tripler Army Hospital after five years duty at Walter Reed Hospital in Washington, D. C.

Dr. Cecil Saunders reported for duty to Brooke General Hospital at Fort Sam Houston, Texas.

. . . and out

Dr. Frederick Lam was discharged from the Army. He is now studying psychosomatic medicine in Baltimore, Maryland.

Dr. Calvin Sia was also discharged from the Army. At present he is continuing his training as a resident in pediatrics.

Dr. Alfred Y. T. Ching was discharged from the Air Force and returned to St. Joseph's Mercy Hospital at Ann Arbor, Michigan, for further training.

Dr. Duane E. Truesdell, formerly resident at the Territorial Hospital at Kaneohe, was also discharged from the service.

Dr. Herbert Pang has resumed civilian practice in Honolulu following his discharge from the Army.

Addressed . . .

. . . the Mental Health Association

Dr. John J. Regan spoke on "The Age of Chemistry and the Treatment of Mental Illness."

. . . the International Institute

Dr. Philip Corboy spoke on "Mexico Today."

. . . Nuuanu Congregational Church

Dr. Roy Ohtani spoke on "The Why and How of Meditation."

. . . the American Dermatological Association

Dr. Harold M. Johnson read a paper by himself and **Dr. Irvin L. Tilden** on reticulohistiocytic granuloma, at the Association's annual meeting, in Santa Barbara.

Travelers . . .

. . . to Denmark

Dr. John T. Kometani and **Dr. Douglas Murray** attended the 8th International Congress of Pediatrics at Copenhagen.

. . . to England

Dr. C. M. Burgess attended the British Medical Association meeting at Harwich, England.

. . . to Austria

Dr. Harold Chandler is doing post-graduate medical work in Vienna.

. . . to Arabia

Dr. Claude V. Caver went to the Far East on an embassy flight for the Navy.

. . . to the Mainland

Drs. William Myers, S. E. Doolittle, L. A. Vasconcellos, T. Shinkawa, Leslie Luke, Tadao Hata, and **Burt O. Wade** returned recently from the Mainland.

. . . down under

Dr. William John Holmes was guest of honor at the annual meetings of the Australian and New Zealand Ophthalmological Societies held at Brisbane and Wellington respectively. Dr. Holmes was elected honorary member of both these societies.

Heiresses . . .

A daughter was born to **Dr. and Mrs. William G. Davis** on August 1, 1956. Dr. Davis is a physician for the Laupahoehoe Sugar Company.

. . . and heirs

Curtis Wah Hoy, fourth son of **Dr. and Mrs. K. S. Tom,** was born at Kapiolani Maternity Hospital on June 28.

Richard Finley Moore, **Dr. and Mrs. William Moore's** first child, was born on July 18, at Kapiolani Maternity Hospital.

Jeffrey Sia, second son of **Dr. and Mrs. Calvin Sia,** was born at Tripler Army Hospital on June 11.

The fourth child and second son of **Dr. and Mrs. Herbert Chinn** was born at Kapiolani Maternity Hospital on July 30.

Married

Dr. William M. H. Dung to Miss Daisy Y. K. Pang in Honolulu. Dr. and Mrs. Dung will live in San Francisco, where he is chief resident at the St. Francis Hospital.

Dr. Kenneth E. Doolittle to Miss Shirley Jean Winfield on June 9, at Rochester, New York.

Dr. Walter E. Printzen to Miss Guadalupe Moreno on June 17 in Guadalajara, Mexico.

Dr. Stanley Sun King Wong to Miss Beatrice Sun Hee Leong on July 28 in Honolulu. The newlyweds will live in New York, where Dr. Wong is a resident at the Cornell University Medical College.

St. Francis Hospital's . . .

. . . new interns

Catalini Cachero, M.D., University of Santo Tómas, Philippine Islands
George Dimitropoulos, M.D., University of Athens, Greece
Lionello Ferrani, M.D., University of Messina, Italy
Pongschai Sukondhayayak, M.D., University of Medical Sciences, Thailand
Manu Sarigaphuti, M.D., University of Medical Sciences, Thailand
Somphongsa Tantisira, M.D., University of Medical Sciences, Thailand

. . . and residents

Adela Garduque, M.D., University of Santo Tómas, Philippine Islands
Wolfgang Pfaeltzer, M.D., University of Frankfort, Germany

Queen's Hospital's . . .

. . . new interns

Max G. Botticelli, M.D., Wayne University
John C. Carson, M.D., Jefferson Medical College
Ann Barbara Catts, M.D., Woman's Medical College
Lawrence W. French, M.D., Wayne University
William P. Grigsby, M.D., Medical College of Virginia
Rose Y. Hagino, M.D., University of Toronto, Canada
John W. Hauzenblass, M.D., Washington University
Milton C. Lee, Jr., M.D., New York Medical College
William J. Rice, M.D., Wayne University
Richard B. Simpson, M.D., University of Michigan
Theodore K. L. Tseu, M.D., Yale University
Daniel L. Yuzon, M.D., University of Oregon
Charles H. Frie, M.D., Indiana University
Sorrell H. Waxman, M.D., University of Toronto, Canada
Allan H. W. Young, M.D., Creighton University

. . . and residents

Kaoru Sasaki, M.D., Creighton University
Albert K. S. Chun, M.D., Creighton University
Victor Hay-Roe, M.D., University of Alberta, Canada
Henry N. Yokoyama, M.D., University of Michigan
Donald W. Brown, M.D., University of Colorado
Jack J. Beckman, M.D., University of Manitoba, Canada
Douglas H. Sandberg, M.D., Bowman-Gray, Wake Forest College
Irwin J. Schatz, M.D., University of Manitoba, Canada
Harold L. Melsheimer, M.D., University of Marburg, Germany
Samuel John Buist, M.D., University of Michigan
Charlette Curtiss, M.D., Western Reserve University

ELLIS ARTHUR STEPHENS, M.D.
1892-1956

Ellis Arthur Stephens was born on July 10, 1892, in Pennsylvania, the son of David A. and Jane Evans Stephens, and died in Honolulu on March 14, 1956. His preliminary education was obtained in Pennsylvania, and his medical degree at the Chicago College of Medicine and Surgery (Loyola University School of Medicine) in 1916. He served in the U. S. Navy, and studied at the U. S. Navy Medical School in 1917, and subsequently did post-graduate study at the New York Post-graduate Medical School and Hospital, the Bellevue Hospital, and the Navy Medical School.

During his naval career, he spent some four years in charge of psychiatric patients in various capacities. He served in 1925-1926 as Editor of the U. S. Navy Hospital Corps Quarterly, and contributed articles on Internal Medicine for a number of years to the *U. S. Navy Medical Bulletin* and to the New York *Medical Journal and Record*. In 1953 Dr. Stephens published a book entitled *Lawless Youth: A Psychiatric Study of the Causes and Prevention of Adolescent Crime.*

Dr. Stephens was a Fellow of the American Medical Association, and a member of the Honolulu County Medical Society, the American Psychiatric Association, the Association of Military Surgeons of the United States, the American Heart Association, the American Association for the Advancement of Science, and Hawaiian Lodge No. 21, Free and Accepted Masons.

On February 1, 1937, during the terminal illness of Dr. Alonzo B. Eckerdt, former Medical Director of the Territorial Hospital, Dr. Stephens was appointed Acting Associate Medical Officer at the Territorial Hospital. In August, 1937, following the death of Dr. Eckerdt, Dr. Stephens was appointed Medical Director, a post he held until his resignation in 1946. Subsequently, Dr. Stephens left and practiced in California for a time, but returned to Hawaii because of failing health.

During Dr. Stephens' administration at the Territorial Hospital, numerous advances were made. The laws pertaining to the Territorial Hospital were rewritten to restore the hospital to medical control and to simplify admission and discharge. The hospital and staff organization was revised in accordance with the recommendations of Dr. Franklin G. Ebaugh. Regular staff conferences for diagnosis, treatment, discharge, and instruction of physicians and attendants were expanded. Classes in group psychotherapy were begun. A liberal policy of trial home visits was put into practice, and many long-time patients were placed in the community, some on defense jobs during the war. Definite parole and follow-up clinics were inaugurated, with the result that the percentage of returned patients was relatively small.

Inductotherm and malarial treatments for syphilis of the central nervous system were instituted. The use of metrazol shock treatment was begun in Janury, 1938, considerably ahead of many progressive hospitals on the mainland, and electroshock therapy was begun in 1940. The groundwork was laid early for insulin treatment, which was begun after the war while Dr. Stephens was still in charge. Pioneer work in prefrontal lobotomy was done at the Territorial Hospital. Plans were begun before the war and completed in 1943 for the new Goddard Treatment Unit, which was finally finished in 1952, exactly according to Dr. Stephens' plans.

Dr. Stephens was an effective and systematic administrator. He made his rounds and inspections regularly. Although primarily an administrator, he was in close touch with the clinical work and was well acquainted with all of the patients and their problems. He continued to improve the food and the manner in which it was served. He encouraged weekly dances, at which patients and employees danced together. He expanded the program of picnics, outdoor games, chess, and bridge parties, and began a beauty parlor for the patients. He continued music therapy and began moving-picture shows on the grounds for the patients.

As is evident from the above, Dr. Stephens was an able and progressive administrator, who continued the good work of Dr. Eckerdt, and continued to utilize the newer modes of psychiatric therapy and practice, amongst the first in the country. He contributed much to the advancement of psychiatry in the Territory and continued Dr. Eckerdt's progress in bringing the Territorial Hospital out of the era of custodial care. His work should properly be acknowledged and remembered.

RICHARD D. KEPNER, M.D.

Kuakini Hospital's . . .
. . . new interns

Kiyoo Beppu, M.D., Keio University School of Medicine, Japan
Ryuji Hirayama, M.D., Osaka Medical College, Japan
Tadashi Kawai, M.D., Hokkaido University School of Medicine, Japan
Koyo Kuana, M.D., Yokohama University School of Medicine, Japan
Emiko Nakamura, M.D., Tokyo Women's Medical College, Japan
Tatsuro Shibanuma, M.D., Chiba Medical College, Japan
Eiji Sumihiro, M.D., Hiroshima Medical School, Japan
Hideo Takahashi, M.D., Chiba Medical College, Japan
Tamon Takahashi, M.D., Tokyo Medical College, Japan

New residents . . .
. . . at Children's

Ralph Hayden, M.D., University of Rochester
Kisuke Nishimura, M.D., Osaka Medical College, Japan
Calvin Sia, M.D., Western Reserve University

(*Continued on page 70*)

TENTATIVE PROGRAM

Territorial Association of Plantation Physicians

November 8, 9, 10, 11, 1956

Kauai Inn—Lihue, Kauai

The purpose of the program of this meeting is to call attention to the close cooperation that exists between the plantation physicians, the Board of Health, and the certified specialists of Hawaii by which the health and medical care are constantly improved for the people of the Territory.

Thursday, November 8

9:00-10:00 A.M.—Breakfast meeting—Kauai Inn. (Please note breakfast meeting starts later on this day to allow participation by doctors arriving on the first morning plane.)
President **Marvin Brennecke** opens meeting.
"Spontaneous Pneumothorax"—**Paul A. Thomas.**
"Which Positive Blood Test Means Syphilis?"—**Sam Allison.**

10:15-11:15 A.M.—Panel Discussion:
"The Team Work Approach on Rehabilitation." **Frederick R. Shephard,** chairman, **Ivar Larsen, Angie Connor, Toru Nishigaya.**

11:30-12:30 P.M.—Panel Discussion:
"Possible Eradication of Tuberculosis in Hawaii." **Hastings Walker,** chairman, **Robert Marks, Peter Kim, Robert P. Henderson, Edward Tompkins.**

12:45-2:15 P.M.—Closed business luncheon meeting with TAPP.

Friday, November 9

7:30-9:00 A.M.—Breakfast meeting—Kauai Inn. Panel Discussion:
"The Use of Tranquilizing Drugs in the Care of Emotional Problems." **Robert M. Spencer,** chairman, **Pershing Lo, Y. T. Wong, R. D. Kepner.**

9:15-10:15 A.M.—Panel Discussion:
"Allergy in Childhood." **F. D. Nance,** chairman, **Clarence Sugihara, Albert Ho, K. W. Amano** (Japan), **Marvin Brennecke.**

10:30-11:30 A.M.—Panel Discussion:
"Enteric Diseases and their Control in the Territory." **James Enright,** chairman, **Grant M. Stemmermann, Archie Orenstein, F. H. Tong, W. E. Iaconetti, Max Levine.**

11:45-1:15 P.M.—Closed business luncheon meeting with TAPP.

2:00 P.M.—Trip to inspect new Eleele Out-Patient Clinic, and Kauai Veterans Memorial Hospital.

8:00 P.M.—Public Meeting: "Diet in Relation to Heart Disease."
Speakers—**Nils P. Larsen,** Honolulu
Robert Wilkins, Boston

Saturday, November 10

7:30-9:00 A.M.—Breakfast meeting. Panel Discussion:
"How to Meet the Problem of Rising Hypertension on the Plantations." **Nils P. Larsen,** chairman, **Keith Kuhlman, Clyde Ishii, Robert Wilkins** (Boston), **Louis S. Rockett.**

9:15-10:15 A.M.—Panel Discussion:
"Asphyxia in the Newborn." **Clifford Kobayashi,** chairman, **Irvine McQuarrie, Clifford K. W. Chock, James T. S. Wong.**

10:30-11:30 A.M.—Panel Discussion:
"Maternal Deaths in the Territory Over the Past Five Years." **Satoru Nishijima,** chairman, **K. S. Tom, William Patterson, Captain James P. Moran, USN.**

11:45-1:15 P.M.—Closed business luncheon meeting with TAPP. Election of officers.

6:00 P.M.—Cocktails.

7:00 P.M.—Banquet—Followed by presentation of certificate of appreciation to "Old Timers."
Guest Speaker—**Dr. K. W. Amano**—"Japan the Beautiful."

Sunday, November 11

Golf tournament—doctors and wives.
Picnic lunch at beach or Kokee.

Hawaii Medical Association

A.M.A. Delegate's Report

It was pretty hot in Chicago last June, over 95° all the time, but the temperature of the House of Delegate's meetings hardly got above that of the air-conditioned room in which they were held.

Only two items of business came in for any oratory at all. One was a Texas resolution calling for A.M.A. opposition to any Federal aid at all to medical schools, even one-time construction grants such as would be provided by Senate Bill 1323, on the ground that the money was tainted by the threat of Federal control of the schools. The Reference Committee on Legislation and Public Relations (Willis Huron of Michigan, Chairman) recommended that it "be not adopted," and despite vigorous opposition to their recommendation (you see how complicated this gets), notably by Alesen of California, Robbins of Arkansas, Schriver of Ohio, and one or two others, it was strongly supported by President Murray, Past Presidents John Cline and Louis Bauer, and others, and carried by a large majority. In other words, the original resolution was defeated.

The other was an eight-page set of conclusions and recommendations arising out of a four-months-old report on private practice by medical school faculty members, presented by the Council on Medical Service with the recommendation that they be studied now and acted upon next November at the Seattle meeting. Immediate action was pressed for, and your Delegate was asked by the California group to move that the conclusions be approved now in principle and acted upon in detail at Seattle in November, after there had been time for them to be studied by those whom they would most affect. Despite strong support of this position by John Cline, Louis Bauer and a few others, pleas for immediate adoption, by men from states now involved in setting up conditions of employment for medical teachers, won by 3 to 1. It was a lesson in practical medical politics, though I'm not quite sure yet what I learned from it.

David Allman of Atlantic City was chosen President-elect without opposition, and Walter Bierring of Des Moines received the Distinguished Service Award.

The present program of hospital accreditation was approved by the House of Delegates in an action which also recommended, among other things, that:

Physicians should be on hospitals' administrative bodies.

Staff meeting attendance requirements should be locally determined.

Reports of accreditation surveys should go to hospitals' chiefs of staff as well as to the administrators.

Accreditation surveyors should work with both staff and administrator.

The Commission should study the problem of limitation of general practitioners' privileges in hospitals.

Hospital privileges should be determined on the basis of professional qualifications and demonstrated ability, especially the latter.

A solo delegate can get along very well at meetings of this busy, select club known as the A.M.A. House of Delegates, thanks to the kindness and cordiality of all the old members, notably those from my home state, Michigan, and our closest neighbor, California. The "Aces and Deuces" organization, made up of delegates from those states sending only one or two representatives, is a great help too, and at this meeting I suggested to its president, Walter Vest, Editor and Delegate from West Virginia, that this organization might well try to maintain a modest "hospitality room," as the more populous states always do, so that we could get better acquainted with one another and also repay some of the lavish hospitality of which we are the willing but somewhat conscience-stricken recipients. This possibility is to be explored.

Mrs. Arnold and I distributed some fifty orchid leis donated by the Hawaii Visitors Bureau, and these were warmly received and carefully saved; many of them appeared on the final night at the reception for Dr. Murray tendered in the Red Lacquer Room of the Palmer House by the California delegation, and though they were a little bit "tired" by Hawaiian standards, they looked pretty spruce considering where they were. We also distributed three or four dozen sprays of hybrid Vandas, Dendrobiums and Phalaenopsis orchids, with a sprinkling of Cattleyas, donated by Dr. Arnold, Sr., Mrs. R. S. Lowrey, and Oscar Kirsch.

The last-night cocktail party for visiting Hawaiians (and Alaskans) ended early; only the Wests, the Bernsteins, and Robert Chung were able to come.

My predecessors are well and warmly remembered by delegates aplenty, and were frequently asked after. It seems unlikely to me that I am carving out any such niche as the deep ones left by F. J. Pinkerton, Bill Hartwell, and Homer Izumi; but I do have the feeling that I'm doing the main job I'm supposed to do, which as I see it is to exercise Hawaii's franchise in as educated a way as

possible, and preserve to the best of my ability the cordial relationship between Hawaii and the other component organizations of the A.M.A., established by those who preceded me.

HARRY L. ARNOLD, JR., M.D.
Delegate

* * *

Diabetes Committee
Minutes

The Diabetes Committee met August 21, 1956. Present were Dr. Togasaki, chairman, and committee members Drs. Caver, Brown, Nakasone, Beddow, Allison and consultant Max Levine. Also present was Miss Harriet Kuwamoto, geriatrics nurse for the Board of Health. Mrs. Garis attended to represent the Woman's Auxiliary. However, in the future they will be represented by Mrs. D. Allen Richardson.

Purpose of the meeting was to formulate plans for National Diabetes Week, November 11-17. Mass testing will again be done in order to attempt to uncover diabetes. Last year 1,466 people were tested and 203 positive reactions were found. Twenty-one were old diabetics, 11 were new diabetics, and 54 were considered incomplete either because of lack of patient or doctor cooperation no blood sugars were done. The Committee wishes to emphasize the necessity for doing blood sugars on anyone who has a positive urine test in order to establish a correct diagnosis.

Plans were made for radio and television as well as newspaper publicity in connection with the National Diabetes Week and Dr. Charles Brown will be in charge.

* * *

Minutes of Council Meeting
Tuesday, August 14, 1956—6:00 p.m.
Oahu Country Club

PRESENT: Dr. Boyden, presiding; Drs. Yee, Nishijima, Pang, Bennett, Wade, Izumi, and Fronk; also Dr. Arnold, Jr., Mr. Kennedy, and Miss McCaslin. Absent: Drs. Hartwell, Patterson, and Oto.

MINUTES: The Council Minutes of May 4, 1955, February 24, 1956, and April 23, 1956, were approved as circulated with the exception of a minor correction in those for February 24, 1956.

FINANCES: *New Bookkeeping System*—A letter from Leman and Hough dated August 9, 1956, stating that a new bookkeeping system for the Hawaii Medical Association should be set up, was read by Dr. Pang. The auditors agree to perform this service for a fee of $150.00.

ACTION: Dr. Yee moved that the bookkeeping system of the Hawaii Medical Association be changed in accordance with the auditors' suggestion for a flat fee of $150.00.

The motion was seconded by Dr. Pang and passed unanimously.

Travel Appropriation: Dr. Boyden pointed out that a president not residing on Oahu incurred extra travel expenses for which there is no specific provision made in the budget. It was agreed it is unfair to expect these presidents to assume all the expenses for their trips to Honolulu to conduct essential business for the Association. The matter of expenses for the Councillors also came up but it was agreed that these expenses should be borne by the county societies.

ACTION: It was moved by Dr. Bennett that travel and per diem expenses should be allowed presidents who reside on the outside islands.

The motion was seconded by Dr. Yee and passed unanimously.

Report on Centennial—The financial outcome of the Centennial Meeting was outlined and although there was a loss incurred on the Pageant, the net profit was tentatively set at $5,455.69. This figure is subject to revision after the auditors have completed their review.

ACTION: Dr. Yee moved that the profit from the Centennial be put in the General Fund.

The motion was seconded by Dr. Pang and passed unanimously.

Telephone—The matter of making a change in the telephone system used by the Association was discussed. A rotary system with three incoming lines to be used in conjunction with the Honolulu County Society was proposed. The cost of this system would be about $6.00 more a month than the one now in use, plus cost of installation which would run between $60.00 and $85.00 (to be divided with the County), but would provide better service to the doctors who now find it difficult to get through to either number now listed for the County and for the Association. The billing for this new system will be equably divided between the County and the Association.

ACTION: It was moved by Dr. Wade that the new telephone system as outlined should be installed.

The motion was seconded by Dr. Izumi and passed unanimously.

HAWAII MEDICAL JOURNAL: On motion of Dr. Pang, seconded by Dr. Bennett, the Council appointed the following Editorial Board for the year 1956-57:

Dr. Harry L. Arnold, Jr., Editor
Miss Lee McCaslin, Managing Editor
Dr. W. J. Holmes, News Editor
Dr. Fred I. Gilbert, Contributing Editor
Dr. Robert A. Kimmich, Contributing Editor
Dr. Webster Boyden, Editorial Board
Dr. H. H. Walker, Editorial Board
Dr. Homer M. Izumi, Editorial Board
Dr. Kay K. Ota, Associate Editor
Dr. Mamoru Tofukuji, Associate Editor
Dr. Stanley Schilling, Associate Editor

Journal Costs:—The JOURNAL costs were reviewed and it was pointed out that the *Star-Bulletin's* increases vary from 30 to 50 per cent an item but they agreed not to put any of these increases into effect prior to the July-August issue. Beginning with that issue and effective for all issues during the balance of 1956, 50 percent of the proposed increase will be charged. The full increase will go into effect with the billing of the January-February, 1957, issue.

Nurses' Withdrawal—This matter was discussed and Dr. Arnold pointed out that this has been a threat for the past three or four years but this year they seem quite determined to follow through. Their reasons for wishing to take this action, the time element and the expense, were outlined. Dr. Arnold asked for permission to bargain with the nurses.

ACTION: It was moved by Dr. Fronk that Dr. Arnold be given carte blanche to handle this situation in any way he may see fit in order to prevent the withdrawal.

The motion was seconded by Dr. Wade and passed unanimously.

On the recommendation of Dr. Yee the Council voiced its heartfelt appreciation to Dr. Harry L. Arnold, Jr., for the invaluable service he has contributed to the Association for the past 15 years as Editor of the HAWAII MEDICAL JOURNAL. As a very small token of gratitude his and Mrs. Arnold's 1957 annual meeting expenses will be borne by the Association.

DISTINGUISHED SERVICE AWARDS: A letter of appreciation from Dr. H. L. Arnold, Sr., was read by Dr. Nishijima. Following this there was a discussion on how the citations should be handled for the 1957 meeting. It was decided that the president of each county society would be asked for nominations to be reviewed at a later date by the Council. No motion was made on this action.

COMMITTEES: *Arrangements*—Dr. Boyden said that this year all members of the Arrangements Committee will be appointed from the island of Kauai. However, he would like the Secretary and the Executive Secretary of the Association to take over the task of lining up the exhibitors. It was agreed that exhibitors will be charged $100.00 each and no partitions will be used. However, it may be necessary to build an outside wall and this cost will be charged to annual meeting expenses.

Chronic Illness—Dr. Mills, the chairman, and Dr. H. H. Walker have asked for a directive from the Council outlining their future activities. Neither doctor was able to be present at this meeting. After a lengthy discussion covering the background, present status, and future activities, Dr. Boyden asked Dr. Arnold to write a letter to the chairman.

Mental Health—Dr. Boyden advised he had received a letter from Dr. Kimmich asking that a Mental Health Committee be formed. A lengthy discussion followed on whether or not this committee should be on a county or territorial level and it was decided to let Dr. Boyden make this decision after the Honolulu County *ad hoc* committee makes its recommendation and after he has talked with Dr. Kimmich. The Council agreed that Dr. Kimmich should have the backing he requests and that it could best be accomplished through a Mental Health Committee.

REPORT OF AMA DELEGATE: Dr. Arnold reported that he had flown straight to Chicago and back and that there was little of a controversial nature at the June AMA meeting, a full report of which appears in this issue of the JOURNAL. Dr. Yee was unable to attend as alternate. As is customary, the Hawaii delegation entertained the doctors there from Honolulu, former Honolulu doctors, and others but there were few who accepted this year's invitation due to the intense heat in Chicago at that time.

Dr. Izumi reported on his experiences as a delegate for the past five years and commented on the policy of having the delegates travel tourist class. It was Dr. Izumi's suggestion that the delegate and his alternate each be given a flat sum equal to the cost of a first-class round trip ticket to the site of the convention plus the costomary per diem expense account of $200.00 and $175.00 respectively for the delegate and the alternate at the summer convention and $175.00 and $150.00 respectively at the winter convention, the delegate to be permitted to use his own discretion in choosing the mode of transportation best suited to his needs for that particular trip. It was agreed that Dr. Izumi's suggestion is the logical solution to this problem. No action was taken.

POLIO IMMUNIZATION PROGRAM: The present status of this program was discussed and the Honolulu County Society's difficulties were outlined by Mr. Kennedy.

VETERANS ADMINISTRATION: The letter dated July 27, 1956, from Dr. Nishigaya, Chairman of the Medical Practice Committee, to Dr. Felix was read by Dr. Nishijima. This letter recommended ". . . that the Honolulu County Medical Society oppose at the present time the removal of the intermediaries in dealing with the Hometown Care Program. The Detroit *Times* of Friday, May 18, 1956, carrying a news item headlined 'Veterans' Medical Plan to Continue in States' recounted how the Veterans Administration in Washington, D.C., arrived at a decision to continue the Veterans Medical Care Plan status quo, after representatives of Veterans of Foreign Wars, Blue Shield, and the Michigan Medical Society went to Washington and pleaded their case." Dr. Boyden advised that Dr. Cheim, of the Honolulu office of the Veterans Administration, had made a trip to Kauai to talk to him and at that time said he could possibly get another extension of the present contract appointing HMSA as the intermediary. However, eventually the Association would have to decide whether or not it will sign a contract direct with the Veterans Administration, agreeing to a fixed-fee schedule that is subject to an annual revision. If the Association does not sign the required contract, Dr. Cheim advised he will be forced to appoint a panel of doctors to carry on the program, thereby eliminating the free-choice-of physician phase of Veterans' Homecare Program in Hawaii. Dr. Boyden suggested that a new letter be written which would employ the best part of Dr. Nishigaya's letter. Dr. Yee said this task should be given the Secretary and the letter should be sent the following veterans' activities: American Legion, Veterans of Foreign Wars, Woman's Auxiliary, Disabled Veterans. It was further agreed that Dr. Boyden has authority to sign an extension of the present contract with the Veterans Administration when it comes up for renewal on September 30, 1956. Dr. Wade pointed out the present fee schedule has never been revised since its inception.

DEPENDENTS' MEDICAL CARE ACT: Dr. Fronk read the report on his attendance at the special meeting held by the AMA in Chicago July 28 and 29. Dr. Fronk, at his own expense, met with various members of the Department of Defense prior to the meeting. In his report he clarified the matter of his having said at the sectional meeting that Hawaii is in favor of Blue Shield as the intermediary, by pointing out this was not an official poll. When the vote for intermediary was taken, he passed.

Dr. Fronk pointed out that it is the Department of Defense's intention to treat Hawaii on the same basis as the mainland states. The AMA has to have its preliminary report in the Pentagon by August 31. The final report is due September 15 and the program is supposed to go into effect December 8, 1956. A discussion ensued on the activities of the Honolulu County's Fee Schedule Committee and their efforts to evolve a relative value schedule. Dr. Yee questioned if it were possible for the Bureau of Medical Economics to act as intermediary but Mr. Kennedy said he was not in a position to state whether or not this would be economically feasible. Dr. Izumi informed the Council the AMA has in essence and in spirit taken the stand that the medical care of military dependents should be provided for at the hometown care level. Dr. Izumi emphasized that we would be letting the AMA down if we do not make a definite statement. It was pointed out that the contract will be for only one year.

ACTION: Dr. Pang moved that we go on record as agreeing to participate in the Dependents' Medi-

cal Care Act. This was seconded by Dr. Wade and passed with one dissenting vote.

Dr. Pang moved that HMSA be appointed the fiscal agent. This was seconded by Dr. Wade. Dr. Izumi moved that this motion be amended to read that the entire matter, including the appointment of a fiscal agent as well as the fee schedule, come up before this Council within one year from the date it goes into effect.

The motion as amended was passed with two dissenting votes.

Dr. Izumi stated that he felt we should have the ratification of the component societies. Dr. Yee suggested that we write back to the AMA and ask them to give us a thirty-day extension during which time this Association can contemplate the matter. Dr. Nishijima felt that we should agree that we will participate.

ACTION: Dr. Wade moved that the actions of the Council be referred to the county societies for ratification and that the AMA be asked for a thirty-day extension for this report.

The motion was seconded by Dr. Bennett and passed unanimously.

Dr. Pang moved that the fee schedule be referred to the Honolulu County Society.

The motion was seconded by Dr. Izumi and passed unanimously.

The meeting was adjourned at 12:05 a.m.

SATORU NISHIJIMA, M.D.
Secretary

Umi Makahiki I Hala*

Personals

The Queen's Hospital has recently added the following new internes: **Dr. Charles S. Judd,** of Yale University Medical School; **Dr. Francis Y. K. Lau,** of the College of Medical Evangelists; **Dr. Robert J. Potts,** of the University of Buffalo; **Dr. Lyle H. Prenzler,** of the University of Illinois. **Dr. John H. Manwaring,** of Stanford University, has become the resident in pathology. **Dr. James Cherry** will be the next resident in surgery, after completion of his internship at Queen's.

St. Francis Hospital now has several new house doctors as follows: **Dr. Edward Matsuoka,** a graduate of the Medical College of Virginia in 1941. He served in the Army for three years. **Dr. Richard You,** brother of **Dr. E. Wonsik You,** of Honolulu, a gradute of Creighton University in 1943, recently discharged as a Captain from the Army after two years of service. **Dr. Thomas Min,** a graduate of Jefferson Medical College in 1942. He was discharged as a Captain from the Army, after three years service in the European Theatre.

The Kapiolani Maternity & Gynecological Hospital has secured the services of two residents, as follows: **Dr. Lyle Bachman,** a graduate of Rush Medical College in 1941, followed by internship in Chicago and residencies in obstetrics and gynecology in St. Louis and New Orleans for four years; and **Dr. Robert P. Jay,** a graduate of Indiana University Medical School in 1944, serving his internship and residency in obstetrics at Methodist Hospital, Indianapolis. Following this he has been in the Navy, continuing obstetrical practice.

Dr. E. A. Stephens, medical director of the Territorial Hospital, Kaneohe, has resigned and is replaced by **Dr. Marcus Guensberg.** Dr. Stephens plans to enter the private practice of psychiatry in Honolulu soon.

Dr. John M. Felix was honorably discharged from the Navy as a Lieutenant (j.g.) and has opened his offices in Honolulu for the practice of medicine and surgery.

Dr. Edward K. Lau, formerly a Major in the Army Medical Corps, has returned to his former practice with the Chock and Pang Clinic.

Dr. John A. Burden, formerly of Puunene, Maui, is being discharged from the Army Intelligence Unit as a Colonel, after five years of distinguished service in the South Pacific and Far East.

Dr. Robert F. Bailey has returned from active duty with the Navy and has resumed his practice in association with **Drs. Culpepper and Honl.**

Dr. Isami Umaki has become associated with **Dr. Richard Sakimoto** in Honolulu, in the practice of obstetrics and gynecology. Dr. Umaki previously was located on Kauai.

Dr. Tell Nelson, until recently a resident physician at Kula Sanatorium, Maui, has opened an office in Honolulu for the practice of allergy.

Dr. Samuel Allison, of the Board of Health, was awarded first prize in the short story section of the American Association of Literary Physicians at the recent meeting in San Francisco of the American Medical Association. The title of his prize-winning story is "I Confess."

* Ten years ago. From Volume 6, Number 1, August-September, 1946.

INTER-ISLAND NURSES' BULLETIN

Official Publication of the Nurses' Association, Territory of Hawaii

MRS. OLIVE C. PRIDGEN, *Executive Secretary,* Honolulu

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GEORGIA MIX, *Editor,* Honolulu

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IRENE ZANE, Honolulu
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MARGARET WATANABE, Maui
JOSEPHINE DUVAUCHELLE, Kauai

PRESIDENT'S REPORT

If thirty-eight years ago the founders of our Nurses' Association could have foreseen the opening session of our 25th annual convention this morning in the auditorium of a building named after one of Hawaii's outstanding nurses, how pleased they would have been. The colorful presentation of flags; the invocation by His Excellency, The Most Reverend John J. Scanlan; the musical program; and the recitation of two pledges sacred to nurses would have left few of these pioneer women without tears in their eyes and lumps in their throats. The nurses who organized our Association over a quarter of a century ago were women of vision with a burning desire to improve the practice of nursing in Hawaii. They made a good start and their successors have followed in their footsteps. Today the Nurses' Association, Territory of Hawaii, Inc., is an important and a highly respected organization. It would be most unfortunate if we were to capitalize on the accomplishments of our predecessors instead of giving our wholehearted support to current efforts to improve nursing in the Islands.

We have with us this morning Mrs. Judith Whitaker, Deputy Executive Secretary of the American Nurses' Association. Mrs. Whitaker is well equipped to help us to crystallize our thinking and to coordinate our attempts to effect a sound economic security program for nurses. We should bear in mind that an ultimate objective of such a program should be a higher standard of nursing care for the community. Mrs. Whitaker cannot do our work for us but her expert guidance and encouragement should make our task much easier. With her assistance it should be possible to progress to a point where the economic security program need no longer engage an undue share of our attention. There are major problems in other areas that merit our earnest consideration.

The number of registered nurses in the Territory who do not belong to the Nurses' Association still presents a challenge. The NATH membership committee worked very hard but as of July 1, 1956, we showed a gain of only 33 active and 8 associate members over the membership figures at the same time last year. The concerted efforts of all of us are needed to meet this challenge.

At its June meeting, the NATH board of directors voted to set up a Territorial Committee on Nursing in National Defense such as is recommended by the American Nurses' Association. Sister M. Laurine, who had attended the Work Conference on Disaster Nursing held in Washington, D. C., last February, graciously consented to be chairman. Your president believes that this is one of the most important committees of our Association at this time.

The wishes of the 1955 NATH House of Delegates regarding the discontinuation of our professional placement service were implemented within the last year. There is some thought now that our action may have been too hasty and that we need a professional placement service on a territorial level. However, it seems too early to reverse our decision, especially in view of the fact that our financial standing has not improved materially.

The legislative program in any state or territorial nurses' association is very important. We

Read before the 25th Annual Meeting of NATH, September 20, 1956.

need to devise ways and means of keeping our membership informed regarding proposed legislation. Likewise we need to establish channels of communication that will enable our committee on legislation to express the views of NATH members insofar as this is possible. These matters will be brought up for consideration during the convention.

Also during this convention, we hope to have a report from a committee set up to make recommendations regarding further follow-up of the Yamamura Report, a study on nursing functions and attitudes in 6 Oahu hospitals during the past year.[1] Studies of this type are highly desirable if we are to improve the practice of nursing.

The 1956 House of Delegates will have an important and far-reaching decision to make when they vote to retain our group subscription with the HAWAII MEDICAL JOURNAL, to substitute a Newsletter, or to have a combination of both. Mrs. Nora Shiroma, the Editor of the Newsletter, and Mrs. Olive Pridgen, Executive Secretary of NATH, deserve high commendation for the excellent issues of the Newsletter that have come to us this year.

NATH has not played an active part in world health in the past. We are entitled to send four members to the eleventh quadrennial congress of the International Council of Nurses to be held in Rome, Italy, from May 27 to June 1, 1957. Perhaps if four representatives from Hawaii can attend, they will do much on their return to stimulate an interest in international health affairs.

Most of the problems confronting us in 1956 are probably much different from those that faced our predecessors in 1931. However, some of them are probably the same. Then, as now, there were great distances involved in bringing nurses from the various islands together for meetings. Even though air transportation today is fast and comfortable, its cost is somewhat prohibitive. There is a total of 318 air miles between a nurse working at Lihue, Kauai, and one living at Hilo, Hawaii. This is one reason why our territorial sections do not seem to be functioning as efficiently as they should. However, the cooperativeness and helpfulness of the individuals who make up our Association compensate for many of the disadvantages under which we labor.

The term of office of your president ends with this convention. She would like to say that she has been greatly impressed during the past two years by the courtesy and support shown her. It has been most gratifying to work so closely with you. While she has always enjoyed the company of nurses and has held them in great respect, her association with NATH members over a period of years has increased her appreciation of the characteristics that seem to be innate qualities of every good nurse. May God bless each of you in the years to come.

SISTER MARY ALBERT, O.S.F.

[1] Douglas S. Yamamura, Functions and Role Conceptions of Nursing Service Personnel, Honolulu, Romanzo Adams Social Research Laboratory, University of Hawaii, December 1955.

EICHINGERS ON A WORLD TOUR

Mrs. Verna Eichinger, a graduate of the Evangelical Deaconess Hospital who has resided in the Territory for long intervals during the past fifteen years, left on September 9 with her husband on a world tour which will take them to England, Italy, Switzerland, and Germany.



MRS. EICHINGER

Returning by way of New York, they plan to fly to San Francisco where Mr. Eichinger has been transferred.

Coming to the Islands in 1941, Verna joined Queen's Hospital as a staff nurse. She held this position for two years. From 1944 to 1950 Verna practiced private duty nursing in San Francisco, Chicago, and Wake Island.

During her residence in the Islands she was active in the district association. She was a secretary of the private duty section for two years, delegate to the convention in Kauai, Maui, and Honolulu. She was on the publicity committee and just prior to her departure was active as a member of the NATH Nursing Information Committee.

Our section joins in wishing the Eichingers a wonderful trip. We will be looking forward to welcoming them upon their return in the not too distant future.

ESTHER KIKUKAWA

MAUI HOSPITALS COMBINE FACILITIES

July 18 marked the beginning of a new era in Maui hospital history. On this day the Hawaiian Commercial and Sugar Company Hospital, located at Puunene, and the Central Maui Memorial Hospital officially merged to create one medical center to serve the entire central area of Maui, the island's most heavily populated section.

Puunene Hospital patients were moved to Central Memorial on July 21. On July 23 fifty-two members of the Puunene Hospital staff joined the Central Memorial staff which makes, according to Mr. Kenneth Kimura, personnel officer, a total of 161 now actively employed by the County of Maui.

This number excludes six employees who are now on leave. Still under the Hawaiian Commercial and Sugar Company are 16 employees who operate and maintain the out-patient clinics at Paia and Puunene.

Central Maui Memorial Hospital has a bed capacity of 152. At present there are 30 registered nurses on the staff supervised by Miss Shizuka Beppu, who until the recent merger was acting director of nurses for Central Memorial, and Mrs. Yoshiko Higa, former supervising nurse at Puunene Hospital.

Miss Beppu feels it is still too soon to judge the efficiency of the new arrangement. The transferring of patients and staff was a major task and there has scarcely been time as yet to adjust to the new regime. It is hoped that it will soon show results in improved medical care and facilities for the people of Maui.

A NURSE IN POST-WAR KOREA



MRS. BO SHIN LO AND MRS. SOON AI YU OF KOREA

Early this year Miss Bo Shin Lo, a Korean nurse studying modern nursing methods here in Hawaii, gave an interesting and informative talk at the Nurses' Association meeting held at Leahi Hospital. In her speech Miss Lo explained her reasons for coming to Hawaii, the Korean situation, the nursing problems and needs in Korea and finally expressed her sincere appreciation and thanks for all the friendliness and help extended to her during her sojourn here on Oahu.

Miss Lo has permitted Irene C. Zane, R.N., to abstract and re-edit the written copy of her speech and present it under her name in the *Inter-Island Nurses' Bulletin.*

"Where did you come from, Miss Lo?" "Are you a registered nurse?" "Why did you travel so far to study nursing, Miss Yu?" "How do you like living in Hawaii?" "What is nursing like in Korea?" These are but a very few of the many questions presented to Miss Yu and me during my year's sojourn here on Oahu. We are always pleased to answer these questions because they show that people feel a kindly interest in us and in what we are trying to accomplish. Because of this evidence of interest I will tell you something about myself, my purposes, the Korean situation, and nursing conditions in Korea today. Miss Yu's story is similar to mine.

In 1935 I was graduated from the Shanghai Seventh Day Adventist Nursing School in Shanghai, China; continued gaining nursing experience as a staff member of various hospitals in China and Korea; and, at the end of the Korean War, I became director of Nursing in the Fusan Sanitarium Hospital in Korea.

During this time I became increasingly aware of the tremendous achievements being made in the medical world in the areas of medicine, patient care, and nursing. This was particularly notable in America and in some parts of Europe. I became convinced that Korea must send her skilled nurses to the western world to gain experience in the newer techniques of hospital nursing and in nursing education. On their return to Korea these nurses would then, through example and teaching, help raise the standards of the Korean Nursing Profession. These conclusions reached, I then sought an opportunity to come to America to learn the modern techniques of nursing and hospital management.

My opportunity arrived in 1954 when I had the good fortune to take and pass the required examinations for all applicants to study in America and in August, 1955, through the help of the American Korean Fund, I arrived in Honolulu.

Mrs. Martelon, director of Nursing at Leahi Hospital, and Mr. Allen, American Korean Foundation Director in Hawaii, welcomed Miss Yu and me with lovely leis and escorted us to our new home in Cottage 2 at Leahi Hospital. We were amazed to find ourselves living in such a well-furnished and comfortable house with a kitchen complete with hot and cold running water. We rarely experienced such luxury in Korea. You may better appreciate how deeply we were impressed by such a warm welcome and how much we have enjoyed our experiences here in this land of beauty and hospitable people when I tell you about Korea and the Korean nursing situation.

Korea is a small country, about two-thirds the size of California, extending out from the northeast coast of China. Although she has a 4,000 year old history, Korea was practically unknown to the western world before the advent of the Korean War some six years ago. Because she was directly involved in the war, Korea has become a land of homeless people, drifting families, hungry orphans, and increasing numbers of "G.I." babies. It is truly a heartbreaking sight to see the many orphan children on the streets struggling for survival because there are not enough institutions or homes to care for them. The hospitals are overcrowded and the doctors and nurses try to care for the many sick people almost without rest. Because of the country's struggle and because of their own personal insecurity, the once peace-

loving people have become bitter and hostile. But they have not given up hope for a better life.

The Korean people are striving vigorously to overcome their national and personal difficulties and to recreate for themselves a better world. They are trying to improve their living conditions and to raise their economic standards. In the southern part of Korea the processes of reconstruction and rehabilitation have been started and new industries are being developed. Efforts are being made to relieve the deplorable socio-economic situation and to improve the health of the people.

Along with the diseases common to peoples throughout the world, a large number of the people in Korea suffer from malnutrition. This is especially true of children. Health teaching and good nursing care for these people has become a very important factor in Korea's rehabilitation and restoration program. With this in mind the nursing profession is struggling against all odds to train nurses who will meet the standards set up by the Korean Nursing Association.

At the present time there are only nineteen nursing schools in Southern Korea and six of these schools are located in the capital city of Seoul. Student nurse enrollment varies from 150 students in the Seoul University Nursing School to 49 students in the Chin-Zu Medical College Nursing School. There are about 1,224 nursing students in all.

Before World War II a graduate of a junior high school between the ages of sixteen and twenty-eight was acceptable for nurse's training. Today the nursing school applicant must have at least a senior high school education. Physical and educational examinations, as well as personality evaluations, are required of the applicant to a nursing school who, if accepted, must train for three years. Having passed all the courses with satisfactory or better grades, the student is given a certificate and, as a graduate nurse, she is then eligible to take the National Registration Examination.

There are about 1,000 nurses in Korea, approximately 700 graduate nurses and slightly more than 300 registered nurses. There are about 600 midwives, 300 of these are registered. It becomes obvious then that Korea has a need for many more qualified nurses.

What then, you may ask, are the working conditions facing the qualified nurse? The Korean nurse works eight hours a day with a day and a half off each week. The shifts are much as they are here in Hawaii. But the nurse's salary will shock you. She is paid the equivalent of thirty American dollars a month. Too, the Korean nurse must expend a great deal more physical energy than is expended by the American nurse because of the shortage in the Korean hospital of nurses, facilities, and equipment. Because of the nursing shortage the director of nurses must frequently work overtime to help out in areas of critical need and all the nurses work very hard to carry out their nursing duties and maintain nursing standards.

Lack of textbooks, inadequate classroom facilities, limited teaching equipment, and shortage of staff teachers and qualified nursing directors present the educator with great difficulties in training nurses to meet the standards set up by the Korean Nursing Association. At present there is only one accredited training school in Korea and there is only one practical nurse training program.

As a help to raising nursing standards by bringing to all nurses information about the newer concepts and achievements in nursing and to bring those in the nursing profession closer to each other, the Korean Nursing Journal was published in 1954. The result of this was a National Nurses' Convention held about two years ago in Seoul but because of financial difficulties there has not been another issue of the Korean Nursing Journal.

Along with efforts to improve nursing standards much is being done to develop health consciousness in the Korean people. April 7 has been set aside as World Health Day. In 1954 Korea celebrated the 100th anniversary of Florence Nightingale's achievements in nursing. All the nursing schools and hospitals in Korea participated in this celebration. At this time the need to help graduate nurses obtain further education and experience in nursing education was brought to the attention of the National Health Council. The Health Council is now working on this problem.

Much has been accomplished but there is much more to be done. Korea has made progress in her efforts toward reconstruction and restoration but she has not done this entirely alone. Much of the credit is to be given to the American medical missionaries and other American organizations who have given help and money with which Korea has been able to expand some of her hospitals and set up treatment units in areas of need. The Korean people are grateful for this generous assistance from the American people. For the greatest part of our nursing achievements we are indebted to the sincere and whole-hearted assistance and guidance, both before and after the war, to the American medical missionaries.

Many nurses from other countries have visited Korea in an effort to improve the Korean Nursing program. We deeply appreciate this. It was through the help of these nurses that during the Korean War we were able to send nurses and medicines to isolated areas where wounded soldiers were in need of medical and nursing care.

Miss Daisy C. Bridges, executive secretary of I. C. N., visited Korea while she was on a visit to the Far East with a group of nurses. We will always remember her great interest in Korea's welfare and all Korean nurses are grateful to her for her valuable guidance and suggestions which she gave us so readily.

Korea has truly needed all the help she has received. She continues to need help. Those of us who hold director of nursing positions in Korea are constantly aware of our need for increased quality and quantity in nursing, our need for better working facilities and equipment in our nursing schools and hospitals, our need to lay a good foundation for future nurses. We realize that our communities need the help of nurses to improve health standards and we know that a good nursing program is vitally needed to help in the rehabilitation of Korea as a nation and her people as individuals. Any help received which contributes to the alleviation of these needs will be appreciated. We hope that the American Korean aid will help finance the next issue of the Korean Nursing Journal. I hope that many of you will send us articles with suggestions and descriptions of nursing in Hawaii so that we may profit from the nursing programs on the Islands. We also hope that many more Korean nurses may be able to come to Hawaii and profit from the fine educational opportunities here.

Yes, I have enjoyed my stay in Hawaii. I have learned many things and I have much to do when I return to Korea.

Bo Shin Lo

A SALUTE TO OUR OUTGOING PRESIDENT

For the past two years the presidency of NATH has been devotedly carried on by Sister Mary Albert, O.S.F.

Sister was born in Lakewood, Ohio, and is a graduate of St. Joseph's Hospital School of Nursing in Syracuse, New York. Later she attended the University of Dayton for her B.S. in Nursing, then went to Catholic University of America for her M.S. in Nursing Education.

In her family there are two sisters and a sister-in-law who are nurses. Of further interest is the fact that she claims a twin brother.

After Sister's assignments at St. Joseph Hospital in Syracuse, N. Y., she was sent to St. Francis Hospital where she is presently Director of the School of Nursing and Nursing Service, a position which she assumed in 1940.

In her early days at St. Francis the hospital bed capacity was 60 as compared to the present 253. The School of Nursing which previously had 30 students now has 125 and there have been as many as 81 graduates a year from the school.

Prior to her presidency, Sister had been active as Vice-President of NATH; Chairman of the Careers Committee, Hawaii League for Nursing; and Chairman of the INSA Section on a territorial level.

Her interests included work on the NATH Economic Security Committee, she served as chairman of its workshop, and a research contribution to the Technical Committee on Hospital Nursing of the Nursing Study Committee. Later this survey was published in book form.

Sister has spent much time and effort with the Scholarship Fund Committee to help local girls. The Scholarship Fund was designed in order that local girls might further their education and establish themselves in the community.

As President of NATH, Sister Mary Albert sustained the members with her splendid example of loyalty to the Association. Her contributions to the nurses of Hawaii are best known by those who had the privilege of belonging to this organization under her leadership.

She was a leader to whom all members responded willingly and happily and everyone recognized in her graciousness a person for whom the dignity of mankind could only be interpreted as "personal trust."

Georgia Mix

I.C.N. MEETING

This is to advise all state nurses' associations that the Eleventh Quadrennial Congress of the International Council of Nurses will be held at the Esposizione Universale Romana (E. U. R. Congress Hall), approximately four miles from the center of Rome, from May 27 to June 1 (inclusive), 1957.

Congress Theme

The theme for the Congress will be RESPONSIBILITY. Subjects for discussion under this theme have been received from National Member Associations of the I. C. N. and are now under consideration by the Congress Programme Committee.

The languages of the Congress will be Italian, French, and English and simultaneous interpretation is to be provided.

A provisional program will be available for distribution later in the year.

Allocation for Attendance

The American Nurses' Association has been given an allocation of 992 places based on their membership figure in the I.C.N. as of December 31, 1955.

An allocation has been set for each state nurses' association based on their membership in the ANA

as of December 31, 1955. The allocation for the Hawaii Nurses' Association is four.

Members of the National Student Nurses' Association wishing to attend the I. C. N. Congress will be included in the allocation established for the SNA.

IN MEMORIAM

Mrs. Mary Dexter

Miss Harriet Delamere

BOOK REVIEW

Textbook of the Principles and Practice of Nursing.

By Bertha Harmer, R.N., A.M., revised by Virginia Henderson, R.N., A.M., Fifth Edition, 1250 pp., Price $7.00, The Macmillan Company, 1955.

This fifth edition is most welcome since the fourth edition was last revised in 1939. The text is intended to be a general reference book for all nurses and nursing students. The author has presented the scientific principles that underlie practice and suggests methods in using these principles.

The text is divided into five parts:

Part I, "The Place of Nursing in Health Service," is a definition of nursing and a discussion of the preparation of the nurse and her place in health programs.

Part II, "Fundamentals of Nursing Care," stresses underlying principles showing in detail how to help a person meet his health needs.

Part III, "The Role of Nursing in Health Evaluation and Diagnostic Techniques," describes the nurse's role in knowing the patient's nursing needs, his physical and emotional status, and in assisting with the diagnostic measures prescribed by the physician.

Part IV, "The Role of Nursing in Therapeutic Measures," deals with the nurse's role in giving or assisting patients with prescribed therapy.

Part V, "Common Problems in Nursing Practice," is a discussion on selected problems that the nurse commonly encounters.

Throughout the text the author has proceeded on the thought that nursing is a service to both the well and the sick and that all branches of medicine have their preventive and therapeutic aspects. She has also indicated that the mind and the body are inseparable and will affect each other. In each case both the emotional or psychological aspect of nursing must be considered.

The appendix includes special procedures, weights and measurements, abbreviations and symbols, normal values of blood, stool, urine, spinal fluid, and emergency first aid. There is also a glossary.

The book has a hard cover and the type is clear and has single column pages. There are also an abundance of illustrations. Because of the detailed material in this text, it will make an excellent reference book.

GEORGIA MIX, R.N.

WHAT HAPPENED IN NATH'S HISTORY—II

In recent years the same progressive spirit of the early days of the Association has continued to spark the work and progress of the organization. Two outstanding examples of this spirit are found in the Margaret Jones Memorial Fund and in the unique character of the Mabel Smyth Building.

After 1918, when the nurses affiliated with ANA, no changes of great moment were made until September, 1930, when again after considerable correspondence back and forth with ANA, complete reorganization took place locally in 1931. The then Nurses' Association, Territory of Hawaii, was set up as the Nurses' Association, City and County of Honolulu, and a representative territorial organization was formed along the lines of the state organizations on the mainland. This structure was maintained until the organization of district nurses' association on Maui, Kauai, and the City and County of Hilo. The first territorial convention, therefore, was held in 1931.

At the first official meeting of the Nurses' Association on April 30, 1917, a constitution was established, Clause 2 of which agreed "to establish a benefit fund for nurses in need." It was unanimously agreed to call this fund the Margaret Jones Memorial Fund. A concert was given at an early date for raising the fund. After all expenses were paid the sum of $514.45 was placed in the savings bank. In July of 1917 the Club received a donation from Mrs. C. H. Cooke which was deposited in the Margaret Jones Memorial Fund.

Miss Mary Johnson, our first president, in her annual report states: "Miss Margaret Jones lost her life in the submarining of S. S. 'Lusitania' off the Irish coast in 1915. During her life she helped from time to time less fortunate nurses. For these two reasons our Club has chosen her name for our benefit fund to commemorate her memory and sad death. We have in the treasury $690.68 as a nucleus to this fund and I am glad to say, so far, no necessity has arisen to use any part of this money."

Inquiry regarding Miss Jones shows that she was a graduate nurse practicing for some time private duty as well as some institutional work in the Territory. She seems to have been universally loved and admired by both patients and friends and well thought of in the community. A year after war was declared she assayed the hazardous journey to England with a widowed expectant mother whose great desire was to reach her British home in time for the birth of her child. They went safely across the Pacific and the continent but were unfortunate to take passage over the Atlantic on the ill-fated S. S. "Lusitania." Miss Jones when last seen stood with her arm about the shoulders of her patient, steadying her with words

of brave encouragement. It is said she gave to her patient her own life preserver and her place in the lifeboat but there is no confirmation of this. Nevertheless, we know that she was a splendid member of the profession, one who lived true to her vows of service even to the greatest sacrifice of all. We are proud to have the privilege of honoring her by giving to this fund her name—a fund which she would have enthusiastically endorsed.

The Fund grew slowly but steadily. The first investment was the purchase of ten $50 Liberty Bonds in October, 1917, and in February, 1918, it was first employed in fulfilling its purpose to provide a tiny income for a retired nurse living at the King's Daughters Home. This was continued in increasing amounts until her death in September, 1926. Requests for assistance made by other nurses from time to time were unfortunately paid from the Fund without due regard to keeping the endowment intact and so later on the finance committee had to make strenuous efforts to rehabilitate it.

However, with careful investments the fund remained stable. The greatest contribution to it, however, was made upon the death of Stella Lowrey, a private duty nurse, from Australia. In 1937 some $20,000 was received from her estate in securities and from the sale of property. This Fund today is still growing and actively assisting nurses who have reasons to need extra funds. There can be no denying the fact that this sort of service to nurses by nurses is in accordance with the highest traditions of professionalism.

The Mabel Smyth Building is unique in that it is probably the only building built for nurses by nurses for their personal use.

Miss Mabel Smyth was a charming and dedicated young woman of part-Hawaiian ancestry. She graduated in 1922 from Simmons College in Boston where she was the first part-Hawaiian nurse to receive a Public Health degree. She worked at Palama Settlement for four years and then started in 1927 with the Board of Health. Always a keen observer of health legislation, she went to Washington, D. C., many times and as a result of these visits made many friends including the late Jane Addams. Looking into the future, she decided before long that the Territory needed a generalized public health nursing program. At that time Palama nurses were doing practically every type of nursing except tuberculosis and so they had Dr. Hiscock come to the Islands in 1930 to make a survey. His report was instrumental in starting a generalized program.

(*Continued on page 70*)



1956 GRADUATES OF THE ST. FRANCIS HOSPITAL SCHOOL OF NURSING WITH BISHOP SWEENEY
Left to right—first row: Yukiko Oshiro, Tomiko Shimabukuro, His Excellency, Most Rev. James J. Sweeney, D.D., Bishop of Honolulu; Grace Arakawa, Rufina Rabbon. Second row: Sueko Kohatsu, Laura Araki, Vera Young, Helen Aragaki. Third row: Juliet Santoki, Yaeko Muranaka, Encarnacion Gerardo, Mary Louise Gilleres, Edna Omiya. Fourth row: Mildred Shozuya, Grace Wong, Charleen Kikugawa, Alice Shinagawa. Fifth row: Molly Yoon, Jacqueline Chun, Yasuko Kusakabe, Jane Masutani, Eleanor Fujita. Sixth row: Shirley Ortiz, Consuelo Izon, Dorothy Murata, Elaine Kuloloia, Lucille Fujimoto. *Not pictured*—Completing affiliations in St. Louis, Missouri: Shinno Arai, Audrey Freitas, Mitsue Kato, Julia Murakami, Jennie Oba, Ellen Sato, Toshiko Uyehara. — *Hinkle's Photo.*

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The blandness of Metamucil makes it an ideal choice for constipation associated with a soft diet, constipation of pregnancy and in the aged and as an aid in reestablishing normal bowel habit after anorectal surgery. Daily use of Metamucil for a limited time will often return an atonic colon to normal function.

Metamucil® is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent. It is supplied in containers of 1 pound—also 4 ounces and 8 ounces.

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SEARLE

NURSES' BULLETIN

(*Continued from page 68*)

Miss Smyth died suddenly, after a short illness, a relatively young woman. She was still active up until her death in nursing and her passing came as a great shock to all of the nurses who had known her and loved her so long.

Finally an idea was formulated and led by Thelma Akana, who was always active in the Nurses' Association. A plan in the form of a memorial building began to take shape. Originally the building was to be for the use of nurses for their recreation and for their meetings solely but gradually the idea and structure changed to include the doctors and an auditorium and, eventually, the establishment we have today.

Mrs. Akana agreed that she would seek the larger subscriptions if the membership of NATH would bring in a goal of $100,000. It must have been a great satisfaction to Thelma Akana when on January 4, 1941, the dedication became a reality.

The beautiful furnishings of the Alice Yates Room, named after Alice Yates, a nurse who worked so many years with NATH, were given by Miss Ethelwyn Castle. The Charles R. Adams Medical Library, gift of Mrs. Adams, was furnished by Mrs. Walter F. Dillingham. The beautiful koa table given by Miss Lucy Ward was made by a great-uncle of Miss Smyth and was originally in the Stella Lowrey Room. The air-conditioned auditorium has over 300 seats which were purchased by devoted doctors, nurses, and friends.

In the words of Miss Laura Hooker, a personal friend of Miss Smyth, "This building is a memorial to a wonderful woman but it also represents the spirit of give and cooperation that exist in Hawaii. To me it's always a source of real pleasure to enter the building. I know of no other building like it that belongs to nurses in the world. This is written mostly for the younger nurses and those to come who know so little of what the building really means, so look around and say to yourself, 'it's all ours to cherish.' "

NOTES AND NEWS

(*Continued from page 56*)

. . . at Kapiolani

Domenico de Mauro, M.D., Universita degli Studi, Italy
Nalini Inamdar, M.D., Nagpur University, India
Mehdi Nohadani, M.D., University of Geneva, Switzerland

. . . at Territorial

Joseph P. Smith, M.D., University of Alberta, Canada
Christopher Bull, M.D., Cornell University
Jaime Amselem, M.D., Madrid University, Spain

. . . at Leahi

Carl Mason, M.D., Stanford University

. . . at Shriner's

George G. K. Susat, M.D., Northwestern University

NEWS

Urology Award

The American Urological Association offers an annual award of $1,000 (first prize of $500, second prize $300, and third prize $200) for essays on the result of some clinical or laboratory research in Urology. Competition shall be limited to urologists who have been graduated not more than ten years and to hospital internes and residents doing research work in Urology.

The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Hotel William Penn, Pittsburgh, Pennsylvania, May 6-9, 1957.

For full particulars write the Executive Secretary, William P. Didusch, 1120 North Charles Street, Baltimore, Maryland. Essays must be in his hands before December 1, 1956.

Fiske Essay on Infertility

The Trustees of America's oldest medical essay competition, the Caleb Fiske Prize of the Rhode Island Medical Society, announce as the subject for this year's dissertation "The Present Day Treatment of Infertility." The dissertation must be typewritten, double spaced, and should not exceed 10,000 words. A cash prize of $350 is offered. Essays must be submitted by January 10, 1957.

For complete information regarding the regulations write to the Secretary, Caleb Fiske Fund, Rhode Island Medical Society, 106 Francis Street, Providence 3, Rhode Island.

Announcement of the Van Meter Prize Award

The American Goiter Association again offers the Van Meter Prize Award of $300 and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The award will be made at the annual meeting of the Association, May 28, 29 and 30, 1957, provided essays of sufficient merit are presented in competition.

The competing essays may cover either clinical or research investigations, should not exceed 3,000 words in length, and must be presented in English. Duplicate typewritten copies, double spaced, should be sent to the Secretary, Dr. John C. McClintock, 149½ Washington Avenue, Albany 10, New York, not later than January 15, 1957.

The essay will be published in the annual proceedings of the Association.



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THIS IS WHAT'S NEW!

(*Continued from page 41*)

dilemma results from the fact that the pathologist finds a 10 per cent incidence of nodular goiter at the time of autopsy, whereas the physician can detect only about 5 per cent on careful examination of the neck. The authors advise **thyroidectomy** in all patients with nodular goiter who are **less than 25** years of age and in those with clinical evidence of **cancer** with lymph node enlargement, hoarseness, etc. In the remaining patients with nodular goiter, they have depended rather heavily on the **radio-iodine uptake.** The hot nodules, those taking up more than a normal amount of radio-iodine, are benign, whereas the **cold** nodules may be benign or **malignant.** The incidence of malignancy in the cold nodules was 23 per cent, with the uninodular goiters having a higher incidence than the multinodular. Among their conclusions, "excisional therapy is indicated for nodules that are considered likely to be carcinomatous." Now then, which nodular goiters should be removed? (*Can. J. Med.* [July 12] 1956.)

* * *

One hundred and seventy-five needle biopsies of the thyroid gland were carried out at the Massachusetts General Hospital over the past four years. Sufficient tissue for histological examination was obtained in 74 per cent. There were no major complications from this procedure. Its greatest value was in the **diagnosis of thyroiditis.** (*New Eng. J. Med.* [Apr. 19] 1956.)

FRED I. GILBERT, JR., M.D.

BOOK REVIEWS

(*Continued from page 48*)

Health and Travel—MD International Symposia.

Proceedings of the First International Symposium on Health and Travel, 70 pp., illus., June 23, 1955, MD Publications Inc., New York City, Chairman Felix Marti-Ibanez.

Since the doctor today is a great traveler and since many of his patients come to him for information about travel, this booklet should be on every doctor's desk.

A few quotes will indicate the tone of the booklet: "Man is the most restless of all living beings. From the very beginning of his existence man has incessantly roamed the earth . . ." "Living is traveling par excellence." The Greeks said: "The essential thing is not to live, the essential thing is to travel."

This booklet comments on travel for children, for old people, on infections in relationship to travel. It lists the various inoculations required and when they should be given. The monograph ends with the following:

(*Continued on page 96*)

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IN MEMORIAM—DOCTORS OF HAWAII

(*Continued from page 44*)

a Honolulu landmark and was a famous social center of the city. The McGrews were widely known for their hospitality and entertained visitors from all parts of the world. The old mansion was built in the 40's by Dr. R. A. S. Wood and was owned at the time of the McGrews' arrival in Honolulu by General McCook, one of the "Fighting McCooks" of Civil War fame.

Later Dr. McGrew and his family purchased the J. F. Hackfield home at Lunalilo and Emerson Streets.

There was little time in the busy doctor's life for trips to the Mainland but in 1876 Dr. McGrew did attend the Centennial exposition in Philadelphia. His second trip came 27 years later when he visited his old home in Cincinnati.

Dr. McGrew had three children, a son, Louis, by his first marriage and a daughter, Mrs. C. B. Cooper, and a son, J. Tarn, by a second wife.

On October 9, 1911, Dr. McGrew fell and fractured his right hip and on November 17 he died at the age of 86.

John Weddick

John Weddick was born in Ireland in 1853.

He received his preliminary education and professional training in his native land. He was graduated from the King and Queen's College of Physicians, Dublin, in 1874 and received the honorable credentials of the Royal College of Physicians and Surgeons of Ireland.

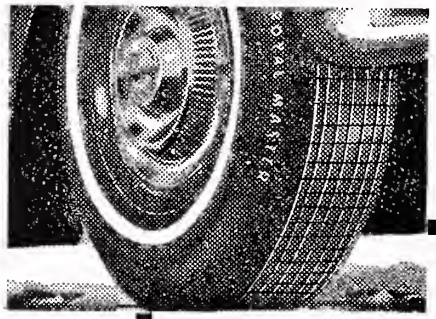
Coming to America in his early years, he finally settled in Hawaii in 1866. For many years he held the responsible position of government physician at various posts on the islands of Kauai, Oahu, and Maui. Dr. Weddick was for some time the superintending physician and surgeon of Malulani Hospital at Wailuku, Maui, the town where he finally made his home and passed his remaining years. He died June 1, 1912, at Wailuku, Maui.

The following is taken from the proceedings of the Medical Society of Hawaii, 1912, page 13. "Dr. Weddick was a typical Irishman with all the admirable qualities and with but few of the weaknesses of that famous race. Those of us whose privilege it was to have been received into his full confidence and into the inner sanctuary of his life found in Weddick a warm-hearted, genial gentleman, entertaining and companionable. His native wit, his kindly, charitable disposition, his sunny, cheerful temperament we love to recall with feelings of thankfulness that we were permitted to know him. He was of that noble company of all-round good general practitioners, in these days not any too numerous, who are content to live and work in the country outside the lime-light of popularity, caring for the sick and distressed in the humbler homes and lowlier walks of life. Never was there a husband and father more devoted to his family life than was John Weddick; and to his afflicted widow and daughter, the Medical Society of Hawaii extends its heartfelt condolence and sympathy."

R. McKibbin, Sr.

Dr. R. McKibbin, Sr. was a native of County Down, Ireland.

He came to the Islands in 1855 and he died March 11, 1876, in Honolulu, in his eighty-first year.



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Frances Matilda Wetmore

Frances Matilda Wetmore was born June 29, 1855, at Hilo, Hawaii. She was the daughter of the missionary doctor, Charles Hinckley Wetmore, and his wife, Lucy (Taylor) Wetmore.

She was educated at Mt. Holyoke College in Massachusetts. After graduation she returned to Hilo and taught in the Hilo Foreign School. Using the money she earned as a teacher, she paid for her medical training at the Woman's Medical College in Philadelphia.

In 1870 Dr. Wetmore returned to Hilo to become her father's partner. Affectionately known as "Dr. Fanny," she was beloved by the Hawaiians and had a circle of friends including nearly everyone on Hawaii.

In the course of a long active life, Dr. Fanny was a member of the Cousins' Society (from 1856), Woman's Board of Missions of the First Foreign Church, trustee of the property of the Aloha Circle of King's Daughters and Sons (charter member in 1889), secretary of the Free Kindergarten Committee, trustee of the Hilo Boarding School (from the time of her father's death in 1898), trustee of the Hilo Public Library, and a member of the Hilo Foreign Church.

On March 12, 1919, Dr. Wetmore died at Hilo within a few months of her sixty-fourth birthday.

Frank N. H. Young

Dr. Frank N. H. Young of Danbury, Connecticut, died March 17, 1868, in New York, at the age of 36. He was a resident for some length of time on Hawaii both in Hamakua and Hilo.

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*Modell, W.: The Relief of Symptoms, Philadelphia, W. B. Saunders Company, 1955, pp. 265-266.

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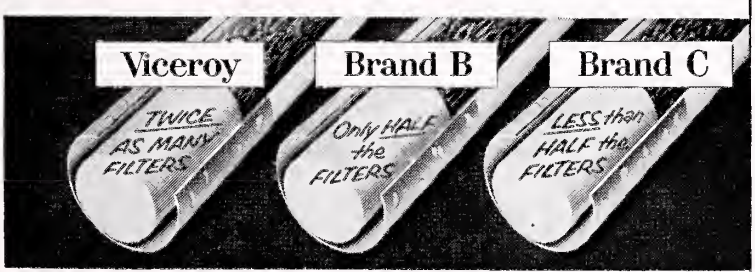


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COUNTY SOCIETY REPORTS

(*Continued from page 51*)

overridden or turned down the wishes of the Honolulu County Medical Society. Your Committee, as well as the members of the Society are well aware of the long hours of devoted service given freely to the HMSA by the lay members of its Board of Directors.

* * * *

Your Committee could not find any evidence that showed the HMSA would be run more efficiently by an increase in the number of physician directors, nor did it find any evidence that the present numerical control of the Board of Directors has ever worked to the detriment of the Society; however, it did feel that there was some need for continued long-range liaison between the HMSA and the Medical Society. The logical individual to increase this liaison would be the Executive Secretary of this Society.

Recommendation:

Your Committee recommends that the Executive Secretary of the Honolulu County Medical Society be made a member of the HMSA Board of Directors and its Executive Committee; that the number of physician directors remain as is for the ensuing contract year. At the end of this period, the subject should be reconsidered. The Committee further recommends that the Executive Secretary of the Honolulu County Medical Society also be made a non-voting member of the HMSA Medical Committee.

Handling Complaints Against the HMSA

Many complaints were received by your Committee relative to everyday working relationships with the HMSA. Upon questioning, it was found that many of the allegations, complaints, and rumors were based on ignorance or misunderstanding.

Recommendation:

In order to prevent misunderstanding and confusion, your Committee felt it advisable to recommend the steps by which a member of this Society should proceed if he has a grievance.

a. Contact the Medical Director of the HMSA and see first if the problem can be solved at this level. (Your Committee realizing the difficulties of administering this position, nevertheless wishes to point out that it is the responsibility of the Medical Director to look after the interests of the members of this Society as well as the interests of the HMSA since the participating physicians contribute substantially to the Medical Director's salary.)

b. If this does not provide a satisfactory solution, contact the Medical Committee of the HMSA which meets monthly, and ask for a hearing. This request should be in writing.

c. If such a meeting does not satisfy the member's complaint, he should write to the Medical Practice Committee, stating the facts of the case and the procedures undertaken and request a hearing.

Investigative Powers of the HMSA Medical Committee

During the hearings the Committee listened to matters relating to abuses of the various medical plans of the HMSA by the physician.

The Committee quickly realized that to have Health Insurance is to have control problems.

We of course oppose undue or increased control of the members of the Medical Society; however, if we are to continue to endorse the principle of voluntary Health Insurance, then we must turn around, face the inherent evils and work out some solution.

One must be extremely cautious that control does not detract from the growth and quality of medicine, and on the other hand must be aware and take definite

(*Continued on page 84*)

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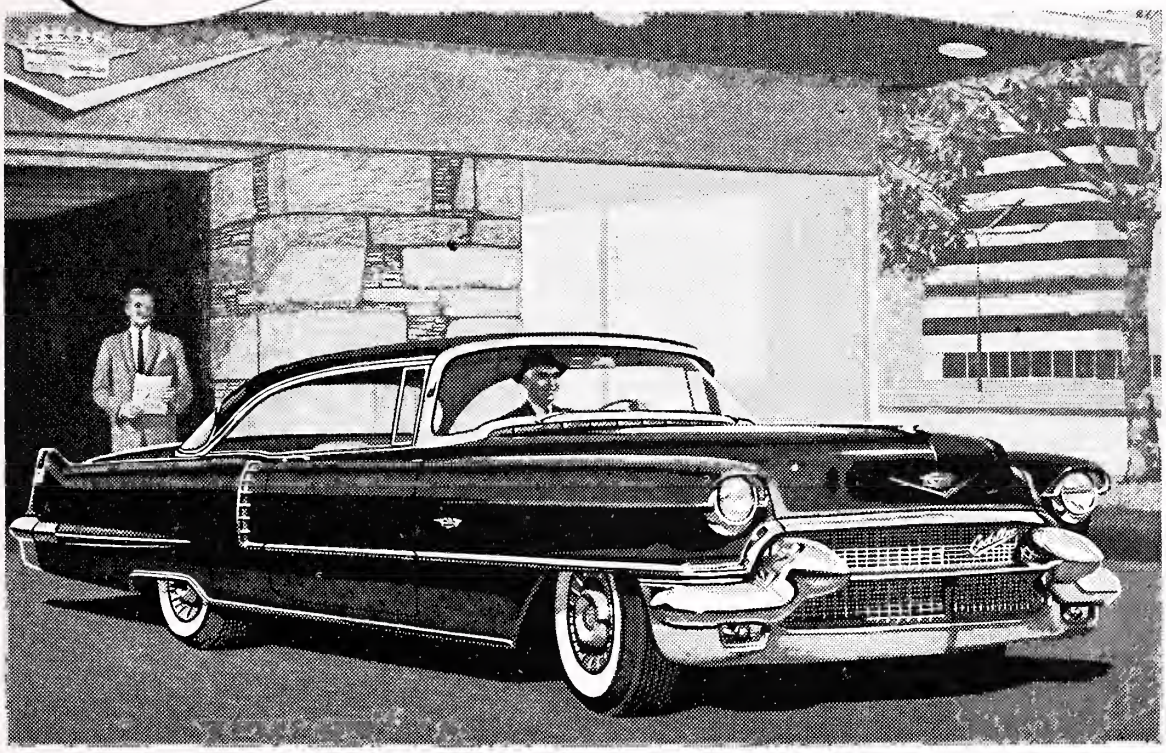
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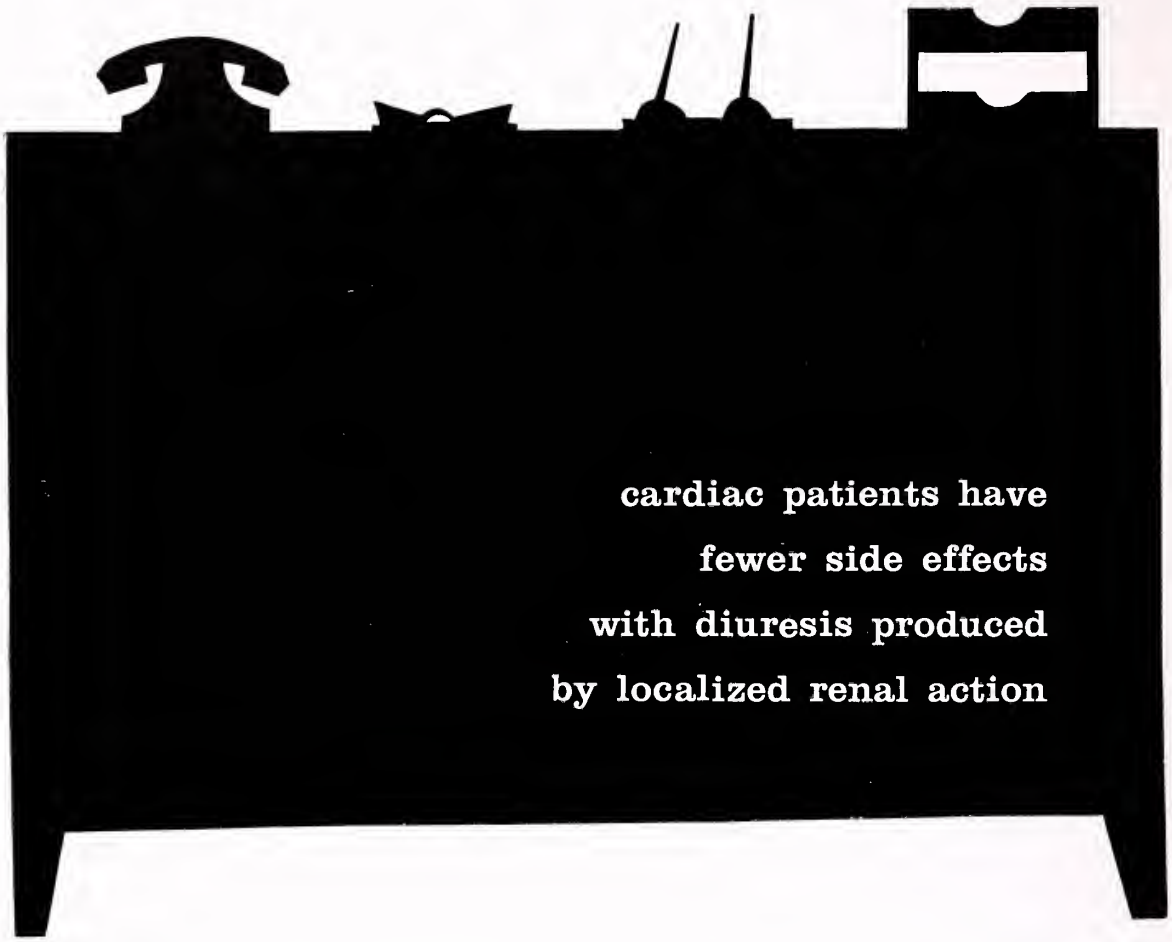
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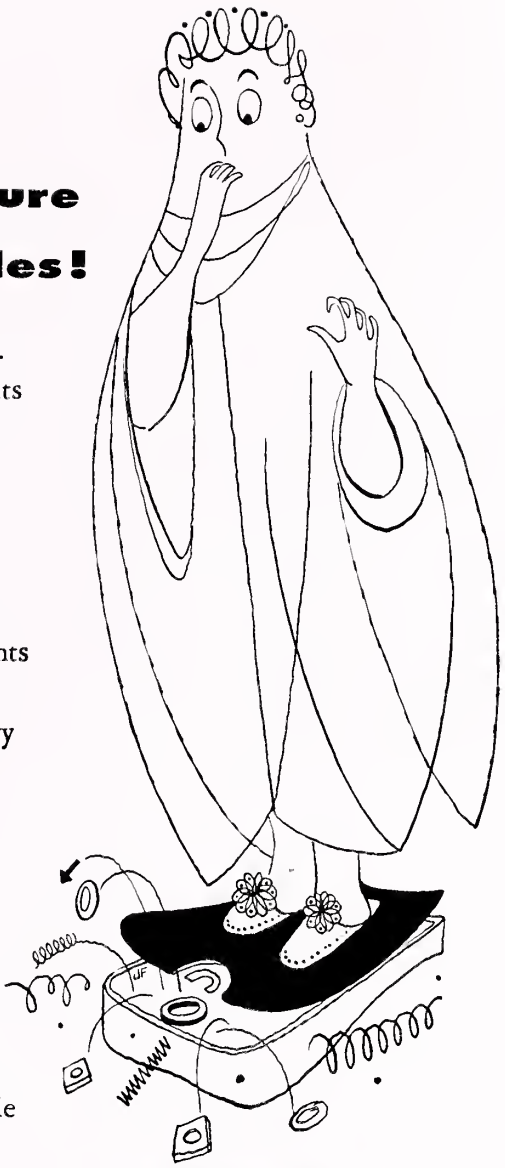
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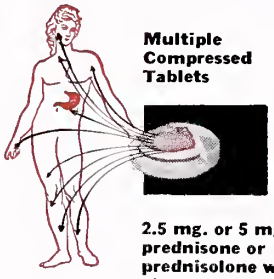
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plus positive antacid action
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Multiple Compressed Tablets

'Co-Hydeltra'
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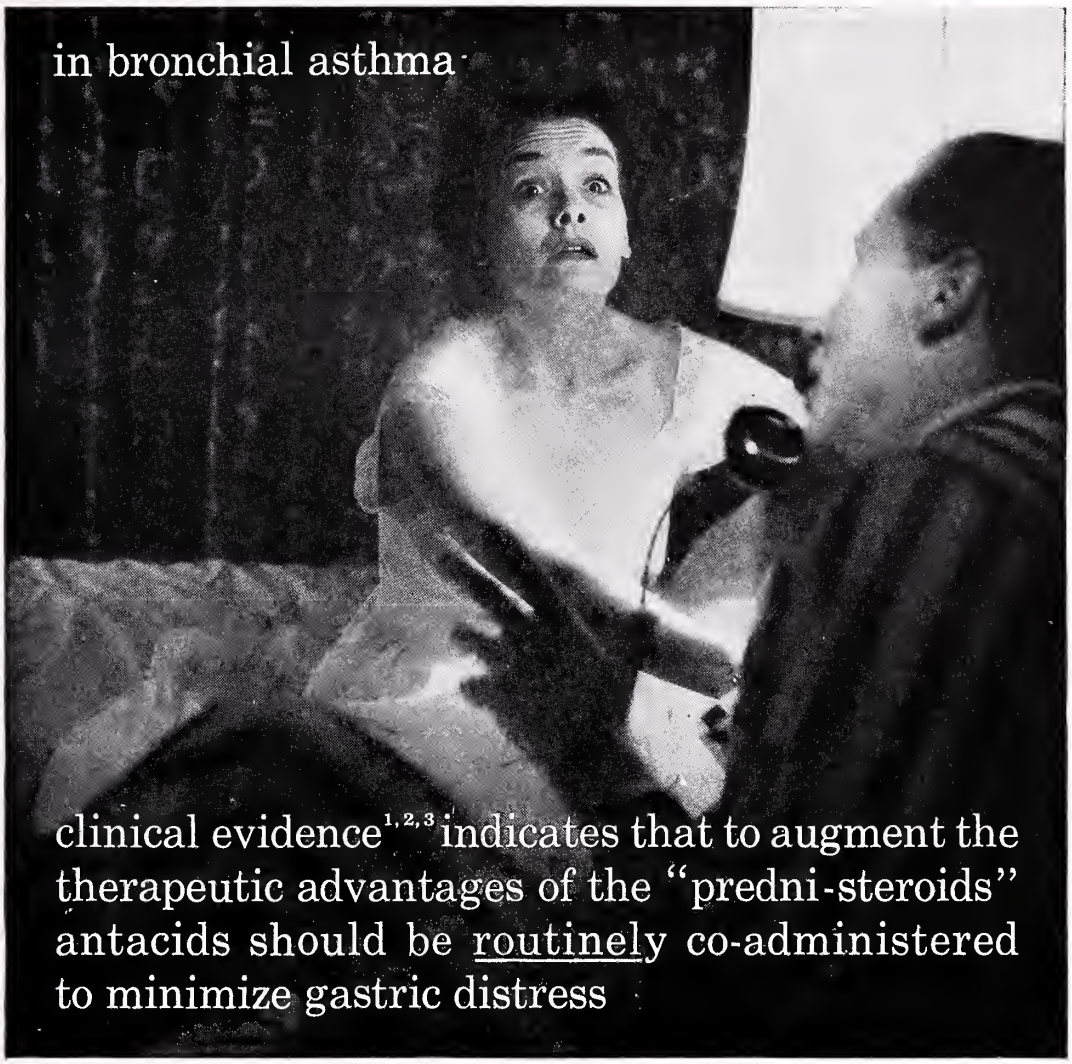
Clinical evidence[1,2,3] indicates that to augment the therapeutic advantages of prednisone and prednisolone, antacids should be *routinely* co-administered to minimize gastric distress.

References: 1. Boland, E. W., *J.A.M.A.* 160:613, (February 25,) 1956. 2. Margolis, H. M. *et al*, *J.A.M.A.* 158:454, (June 11,) 1955. 3. Bollet, A. J. *et al*, *J.A.M.A.* 158:459, (June 11,) 1955.

MSD

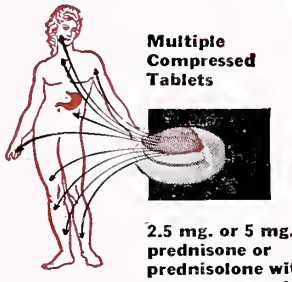
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References: 1. Boland, E. W., *J.A.M.A.* **160**:613, (February 25,) 1956. 2. Margolis, H. M. *et al, J.A.M.A.* **158**:454, (June 11,) 1955. 3. Bollet, A. J. *et al, J.A.M.A.* **158**:459, (June 11,) 1955.

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COUNTY SOCIETY REPORTS

(*Continued from page 78*)

steps to control any doctor who attempts to take advantage of Health Insurance plans for financial reasons.

* * * *

The main problem seems to center around the number of visits a doctor sees a patient per illness and/or the number of times any one particular doctor hospitalizes his patients. The Committee feels that in cases such as these, that a comparison of how a doctor handles non-insured patients against insured patients might be helpful in addition to the present methods used. In a comparison such as this the investigating body might be able to more accurately tell if a physician is abusing an insurance plan or if it is merely his way of practicing medicine.

Recommendation:

Your Committee recommends that it shall be the duty of the HMSA Medical Committee to review and investigate complaints of abuses with the physician or physicians involved. If the matter cannot be settled at this level or if some action is indicated against the physician, then the whole case shall be referred to the Medical Practice Committee of the Honolulu County Medical Society. (This recommendation shall not be interpreted as authority for adjudicating power or for the imposing of disciplinary action on a member of this Society by the Medical Committee of the HMSA.)

Lists of Participating Physicians

A frequent complaint of physicians who did not choose to participate in the HMSA Community Group Medical Plan was the presence of a list of participating physicians furnished to groups or individual members.

Originally this was part of the contract (Para. 9) between the Honolulu County Medical Society and the HMSA, signed April 1, 1952. This paragraph reads as follows: "The HMSA agrees to make available at all times to its members a list of participating physicians as may be supplied to it by the Medical Society, but shall not be required to publish revisions of the list of participating physicians more than twice in each contract year."

The lists were never published prior to the appearance of the Community Group Medical Plan because only four members of the Society did not participate in the HMSA basic plans. When a large number of physicians did not participate in the Community Group Medical Plan the bi-annual publishing of lists of participating physicians was begun by the HMSA.

* * * *

Recommendation:

Your Committee recommends that in order to prevent disturbance of the privileged relationship existing between a physician and his patient, a Code of Behavior for the HMSA employees is to be drawn up by the HMSA. Subject to approval of the Board of Governors of the Honolulu County Medical Society, this Code of Behavior is to be distributed to the membership of this Society. Violation of this Code of Behavior shall be cause for dismissal of the employee involved. The Committee further recommends that no general distribution of the list of participating physicians be made.

(*Continued on page 88*)

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"In our opinion, the new contraceptive cream [DELFEN vaginal cream], when used alone, is highly spermicidal, and a satisfactory method of conception control. Its relative simplicity makes it very acceptable to the patient."*

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*This study included 227 patients for a total of 2031 woman-months.

Behne, D.; Clark, F.; Jennings, M.; Pallais, V.; Olson, H.; Wolf, L., and Tyler, E. T.: Clinical Effectiveness of a New Vaginal Contraceptive Cream; A Preliminary Report, West. J. Surg. 64:152, 1956.

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1. Freeman, B. S.; and Young, T. K., Jr.: *Arch. Surg.*, 61:1145, Dec., 1950. 2. Shay, D. E.: *Oral Surg., Oral Med., & Oral Path.*, 4:355, Mar., 1951. 3. Canzonetti, A. J.; and Dalley, M. M.: *Ann. Surg.*, 135:228, Feb., 1952. 4. Bowers, R. F., in discussion of Price, P. B.: *Ann. Surg.*, 134:476, Sept., 1951.

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in hay fever and other respiratory allergies,
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COUNTY SOCIETY REPORTS

(*Continued from page 84*)

It should be *made available* only to those subscribers who are eligible for service benefits.

* * * *

Service Benefits & Income Levels

One of the most frequent complaints stated, that the present income levels of $7500 for an individual and $10,000 for a family were too high. Of the 199 physicians who answered the questionnaire, 118 thought that these income levels were too high.

* * * *

Why the service benefit feature, anyhow? The Committee felt that a service benefit insurance plan meets a natural desire among people in the low income brackets, whom these plans are primarily designed to serve; that their premium payments will at least pay for the services eligible under their contracts. It assures them that they will not be asked to pay more for these services than the doctors have agreed to accept as adequate payments through their own plan.

Whether the service benefit program operates with general satisfaction or the opposite depends largely on several factors. First, the income level within which service benefits apply should be realistic. Equally important, the schedule of payments provided by the plan should be a true and acceptable average of the fees normally paid in the particular community by families within the income level of the plan.

The Committee felt that the doctors' primary interest should be to provide the most complete medical coverage possible for those individuals who otherwise would have difficulty in obtaining it without a service type of Health Insurance.

The Committee feels it is the obligation of the Medical Society to maintain and encourage as high a standard as possible. If a relationship between an insurance concern or its physicians tended to encourage low standards, either by virtue of fee or type of service agreed upon, this would not be healthy either in terms of standards of medical care or on a practical level because people would undoubtedly become dissatisfied with it.

Recommendation:

Inasmuch as it has been the responsibility of the medical profession to provide medical service for the low income groups, it is the recommendation of this Committee that we continue to support the service feature in Health Insurance. It is further recommended that the following income levels be set:

Single Subscriber$3600.00
Family Subscriber$4800.00

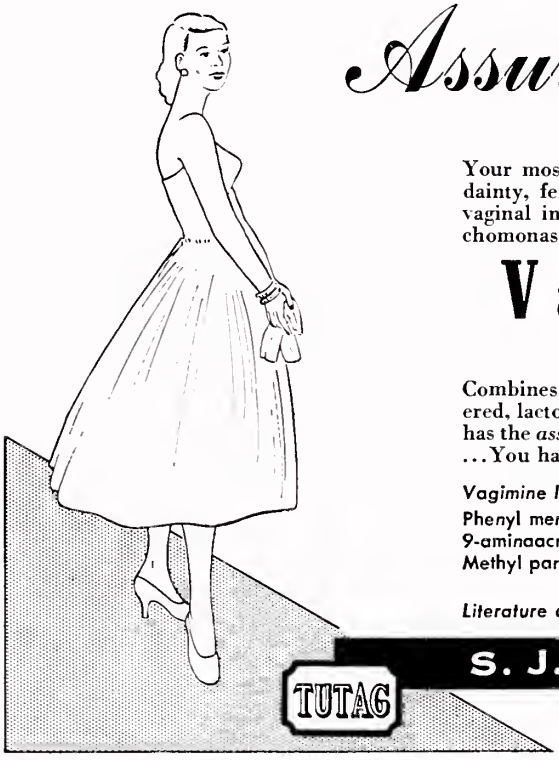
(The figure of $4800.00 for a family will cover 50% of the families in the Territory.) Above these levels people will be served on an indemnity basis.

During the Committee discussions regarding income levels, there were many times when the physician felt that HMSA itself should undertake the job of determining income levels, rather than it be the responsibility of the doctor's office.

* * * *

Recommendation:

Your Committee recommends that in the future, rather than changing the claim form of the HMSA,



Assurance...

Your most fastidious patient will not hesitate to use this dainty, feminine, yet medically proven specific for vulvo-vaginal infections. Clinically effective in Leukorrhea, Trichomonas and Monilia vaginitis.

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VAGINAL INSERTS

Combines 5 gentle but potent anti-microbial agents in buffered, lactose-dextrose base assuring proper pH. Your patient has the *assurance* of *prompt*, effective relief at moderate cost ...You have the *assurance* she will use them as prescribed.

Vagimine Inserts contain:

Phenyl mercuric acetate	3.5 mg.	Tyrothricin	0.5 mg.
9-aminoacridine hydrachloride	2.0 mg.	Hyamin 10X	2.0 mg.
Methyl para hydroxybenzoate	7.0 mg.	Succinic acid	15.0 mg.

Buffered Lactase-Dextrose base q. s.

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that the HMSA determine the income level of the subscriber at the time of application, and if the subscriber is eligible for service benefits then his identification card will have the word, "SERVICE" superimposed across the face of the identification card. If the patient is not eligible for service benefits, then his identification card should be of a different color and the word, "INDEMNITY" superimposed across the face of the card.

In making this recommendation the Committee is aware that in many cases the subscriber's income will vary, and at times he or she will no longer be eligible for service benefits. It is therefore further recommended that a paragraph be included in the policy to the effect that the subscriber is responsible for notifying the HMSA at anytime his income or family situation changes so that he is no longer eligible for service benefits.

The Committee felt that service benefits are made available to help the patients in the low income bracket budget for his or her medical bills, and that if he or she is able to buy additional insurance and/or order additional services in the hospital, then the service benefit should not apply.

Recommendation:

Your Committee recommends that a clause be added to the policies stating that, "When a patient voluntarily chooses hospital accomodations above the semi-private level or carries more than one Health Insurance policy, he or she is no longer eligible for service benefits no matter what his or her income may be as long as one of the above conditions exists."

Your Committee feels that it is in our best interests for the HMSA to acquaint public groups or individuals with the fact that when we talk about Service medicine we are merely talking about a specific type of medical coverage and not a Shangri-La state and that Service features such as first call will increase the administrative cost of policies and could, ultimately, amount to much more than certain individuals concept of prepayment.

Recommendation:

Your Committee recommends that as our representative, the HMSA should continue in their efforts to correct any misunderstanding the public might have, that Service plans can or are providing all inclusive services for minimum premium dollars. (This as a philosophy has, of course, obvious merits but certain people may have a very positive feeling about government medicine because of their misunderstanding that it is possible to obtain all-inclusive medical service of an adequate caliber at a low cost.) The HMSA should be encouraged to develop other insurance plans so that they can incorporate the desirable features of co-insurance and deductible components such as already exist along with low cost risk types of insurance, with coverage for catastrophic conditions. It would appear that catastrophic coverage has obvious advantages to the patient and would be a valuable contribution to the physician because:

a. The doctor is often not compensated for more chronic and catastrophic illness, even though they often treat patients during such an illness.
b. The government is making definite inroads of an increasing nature in the treatment of catastrophic illness. This is, of course, one area whereby many feel socialized medicine may someday be a reality.

* * * *

(*Continued on page 90*)

"...in patients with moderately severe and severe cardiac failure, neohydrin is the oral diuretic of choice."*

*Moyer, J. H., and others: J. Chronic Dis. 2:670, 1955.

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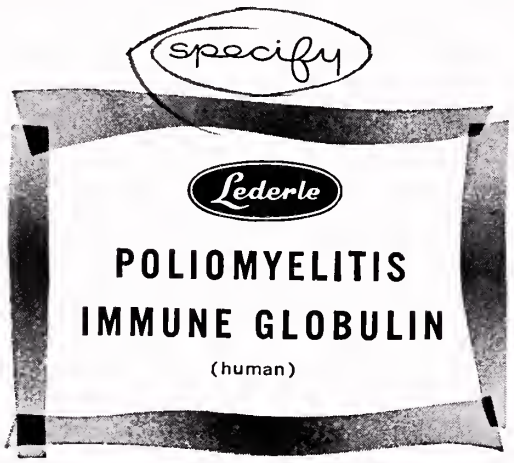
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COUNTY SOCIETY REPORTS

(*Continued from page 89*)

Fees

Almost every physician who appeared before your Committee felt that the present fees of the HMSA insurance plans were too low. This is also reflected in the questionnaire where 112 out of 194 replying said that the present fee schedule was not adequate for the income limit of $10,000.00.

In this regard, it again became very apparent, from the testimony of the physicians appearing before this Committee, that there was an alarming lack of knowledge as to what fees they were permitted to charge.

An equitable fee schedule is one of the requirements for a successful insurance plan. Without such a fee schedule there is dissatisfaction even among the participating physicians and the success of a plan becomes jeopardized.

At the present time your Fee Adjustment Committee is engaged in an extensive project to determine an average fee schedule for this Society. When this is completed it will be most helpful in determining an adequate and equitable fee schedule. For this reason your Committee has not undertaken a detailed discussion of the fee schedule.

Certain principles in regard to the fee schedule need to be emphasized, however. It certainly makes little sense to complain about the HMSA's part in determining fee schedules. These fee schedules have and must be established through the proper instrument of this Society, the Fee Adjustment Committee. If an individual, or a group, feels that the fees are too low, then they should consult with this committee (Fee Adjustment Committee). Periodic readjustment of fees, perhaps on a yearly basis, should be a function of the Fee Adjustment Committee. At these stated times, any member of the Society who felt the need to express his opinion about the current fees would have an opportunity to do so.

Recommendation:

Your Committee recognizing that an equitable fee schedule is a key factor in the success of any medical care plan, recommends that such fee schedules be established by this Society itself through its Fee Schedule Committee. It further recommends annual reevaluation of medical care plans fees by this committee. If any member of this Society wishes to express his approval or disapproval of such fees, he will thus be provided with the opportunity for so doing.

* * * *

Community Group Plan 20% Deduction

Without doubt the 20% deduction from the doctors' fees undoubtedly created much of the initial opposition to the Community Group Medical Plan. Its purpose, as you will recall, was to provide premiums which would be competitive with a closed panel plan. Subsequent experience, during the first six months of the plan was satisfactory enough so that the 20% deduction was returned to the participating physicians of the Honolulu County Medical Society. Whether or not the same will hold true for the remainder of the contract year will of course depend upon the actual experience.

Recommendation:

Your Committee recommends that:

a. The present 20% deduction of fees in the

(*Continued on page 92*)

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Brittle, fragile or laminating fingernails are the bane of many a woman's existence. Yet this highly prevalent and distressing condition often has gone uncontrolled for lack of effective therapy. Now, you can promise these patients substantial relief in a large percentage of cases.

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Optimal dosage proved to be one envelope (7 grams) of Knox Gelatine administered daily for three months. Improvement, however, was noted after the first month. If you would like more complete details of this work, just use the coupon.

1. Rosenberg, S. and Oster, K. A., "Gelatine in the Treatment of Brittle Nails," *Conn. State Med. J.* **19**:171-179, March 1955.
2. Tyson, T. L., *J. Invest. Dermat.* **14**:323, May 1950.

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Professional Service Dept. SJ-18
Johnstown, N. Y.

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COUNTY SOCIETY REPORTS

(*Continued from page 90*)

HMSA Community Group Medical Plan be discontinued immediately.

b. If it is necessary for the members of the Honolulu County Medical Society to underwrite future HMSA plans, then this period of underwriting by the participating physician should be for a definitely specified period of time, not to exceed twelve calendar months.

* * * *

Maximum Allowed Medical Fees

The maximum fees that were established in the medical section is probably the most misunderstood part of the Community Group Medical Plan. Your Committee found that most doctors did not know how to correctly apply these maximum fees to their practice.

It also became apparent that there were certain inequities between maximum medical fees and maximum surgical fees. For example, if a surgeon runs into a difficult and complicated surgical procedure, he (the doctor) may request from the Medical Director additional compensation, and in most cases receives it. In the case of a medical fee, however, if the doctor runs into a difficult problem either in the office or home and is stuck with it for any length of time, he has no relief, as the plan only pays $3.00 in the case of an office visit and if it is the first call the doctor can only charge $7.50. If it is a second or subsequent call the doctor can then only charge $4.00.

This problem of maximum charges is also a very sore point with some of the specialists in the medical field. However, complaints were also received from the general practitioners. Some doctors felt that maximum fees such as these might alter ones way of practice, and would certainly invite abuses in the way of increased office visits.

Recommendation:

Until some solution to these inequities can be reached, your Committee recommends that the maximum charges allowed in the medical section of the Community Group Plan be eliminated.

* * * *

The Committee supports the concept of Health Insurance for as many people as possible. If we find that insurance plans are valuable or believe they are definite trends, we should attempt to cover as many people as possible. This would necessitate varying plans to account for varying groups including the insurability of individuals as well as to account for the uniqueness of their demands. Increasing the insurance coverage would necessitate the maintenance of good relationships with all insurance companies not only because we can't expect all people or groups will be interested in the HMSA but because a healthy interaction is positive. This of course does not mean that we necessarily change our relations with the HMSA, for they do offer the medical profession an excellent sounding board. Also, the HMSA affords us an excellent medium for the development of various plans to expand and refine present insurance coverage in a practical and workable sense.

During the height of the medical profession's fight against government medicine, an intensive advertising campaign was waged which stressed the merits of voluntary plans over government-operated plans. But because the issue seems temporarily dormant, we must not be lulled into false security and allow promotional efforts on behalf of voluntary plans to lag. The success or failure of our present medical care system rests largely upon the future of voluntary Health Insurance in the country. In addition, competition from closed-panel insurance programs, which on the surface look highly appealing to most people, makes continued efforts to sell voluntary Health Insurance and its merits imperative. Voluntary insurance cannot continue to make strides ahead unless physicians actively support it, as the saying goes, in word and deed.

What are the factors which color the labor-medicine relationship? First of all, workingmen seem to harbor no resentments against the average doctor, but are highly distrustful of organized medicine. There is not lack of understanding between the worker and his physician, but there is considerable misunderstanding between the leaders of both sides. Misconceptions lead to frictions which create a false barrier between the two sides. It is the task of the medical profession—a task of tremendous PR significance—to erase misconceptions and replace ignorance with mutual understanding. Out of mutual understanding will come mutual respect.

To accomplish this goal, it is necessary to know some of the complaints of labor about medicine. Labor generally seems to blame the medical profession for high surgical and hospital costs. The medical profession should do what it can to lower these costs—and also explain why certain charges remain at their present levels. There are some Union men who express the belief that voluntary Health Insurance is a good idea, but feel that compulsory Health Insurance is an economic necessity. This opinion stems partly from the lack of cooperation of some elements of the medical profession in making voluntary plans successful.

Recommendation:

In order to erase misconceptions and replace ignorance with mutual understanding between Labor, Insurance Companies who write Health Insurance, and the Medical Profession, your Committee recommends that the "Medical Care Plans Committee" be made a standing committee of the Honolulu County Medical Society. In order to make use of the experience gained by the committee members, this should preferably be an elected committee, having a total of six members, (two members being elected each year to serve for three years.) The committee would elect its own chairman from one of the two senior members in point of service.

The duties of this Committee would be as follows: To advise Labor and Insurance Carriers in preparing a schedule of fees for its insurance plans; to set up certain insurance plan specifications; to advise and assist on all professional matters related to Health Insurance plans; to review annually all Health Insurance agreements that the Society may have which will include the Veterans Hometown Care Program, the Workmen's Compensation agreements, the HMSA contract, and any agreements the Society may have with a commercial insurance carrier, City & County, Territorial, or Federal government; to act as the liaison between the medical profession and *any* organization, but specifically, insurance carriers, labor, and management with problems regarding Health Insurance and/or Medical Plans.

The Committee will refer all problems with regard to fee schedules to the Fee Adjustment Committee and all problems of abuses, falsifying insurance forms, and excessive fees will be referred to the Medical Practice Committee. If deemed necessary the committee may request a joint meeting between itself and any other committee in the Society. All matters referred to another committee from this committee must be referred back to this

committee for acknowledgment before any official report is made.

Any committee within the Society taking up matters that directly or indirectly concern Health Insurance and/or medical plans will forward the findings and/or recommendations to the Medical Care Plans Committee for their acknowledgement before any official report is made.

The Committee shall not have the power to make agreements for the Society without the membership approval.

Finally as a temporary duty, to take the necessary action and steps to see that the recommendations of the temporary Medical Care Plans Committee as approved and/or amended by the membership are carried out.

Panel Practice

While this Society is opposed to the closed panel type of medical practice, it is important to recognize that there are types of closed panel medicine existing in this community.

It has been brought to the attention of your Committee by the members of this Society that two specific instances of panel practice are now current. One is a contract between an employer and a group of doctors in this city to provide for the medical services of the employees.

The other instance is that existing in certain rural areas of Oahu where an employee is denied hospital and medical expenses if he consults a physician other than that provided by his employer.

While a contract between an employer and a physician is not unethical per se, in both of these instances there is definite violation of the right of the individual to free choice of physician. In this respect, these instances constitute closed panel practice of medicine and, as such, are to be condemned.

Recommendation:

Your committee has not investigated these allegations brought before it, because of time limitations. It recommends that the information it has been furnished be given to the Medical Practice Committee for proper action.

Respectfully submitted,

MEDICAL CARE PLANS COMMITTEE

L. A. R. GASPAR, M.D.
E. HARRIS, M.D.
R. D. MOORE, M.D., CHAIRMAN
T. NISHIGAYA, M.D.
S. L. YEE, M.D.

A motion to accept the recommendations of the Medical Care Plans Committee was made by Dr. R. C. Durant who moved, "That the report of the Medical Care Plans Committee be approved in toto as presented; that all specific recommendations in the report be put into immediate effect; and that the Medical Care Plans Committee be charged under our President with expediting the actions recommended in the report." The motion was seconded by Dr. Palma and carried with three dissenting votes.

A request by Dr. Felix to have the present Medical Care Plans Committee continue in its present capacity as the Medical Care Plans Committee of the Medical Society until the annual election was unanimously approved by the membership.

In closing Dr. Arnold, Jr., proposed that the Society thank the Committee and compliment them on a job extremely well done and so moved. The motion was carried unanimously.

The meeting was adjourned at 8:05 p.m.

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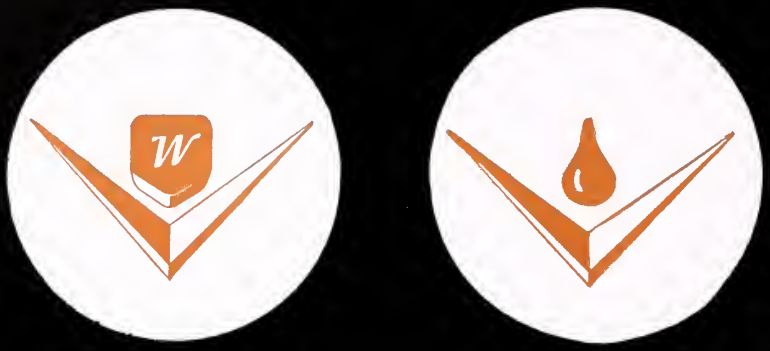
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1. Martin, W. J., et al.: J.A.M.A. *160*:928 (March 17) 1956.

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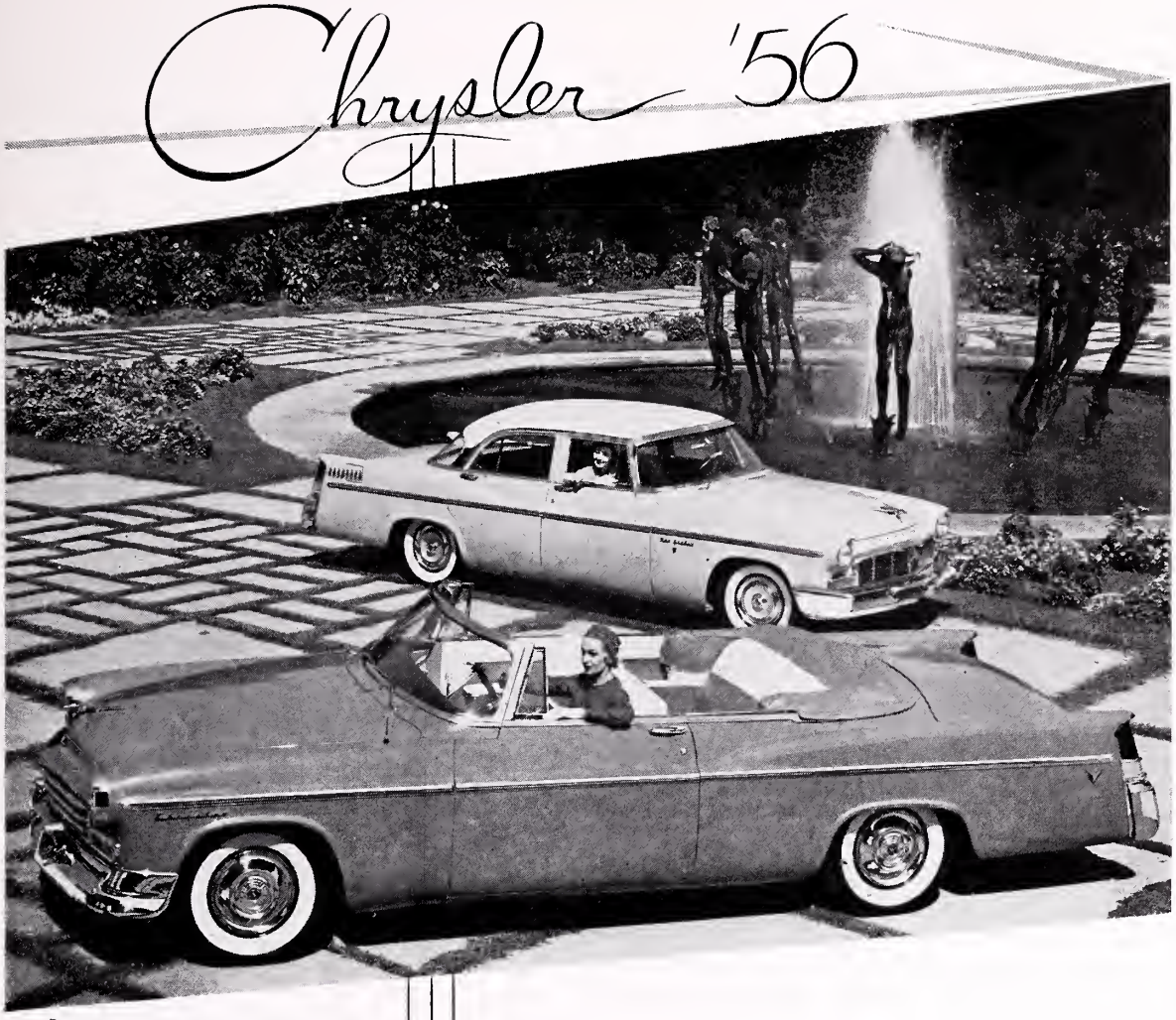
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BOOK REVIEWS

(*Continued from page 72*)

"On this planet of ours, where land and sea have already been conquered, hope is represented by medicine, which will make possible space travel—man's new goal—and the conquest of health in peace on the shoreless ocean of time."

One practical suggestion for a recommended travel bag was to carry empirine with codeine, chor-trimeton, thorazine, paregoric, cremalin, bonamine (best anti seasick remedy), aralan, diodoquin, desenex powder, teramycin SF 250 mg., caffergot, and as a cold remedy early in colds, codeine and papaverine ¼ gr. each.

NILS P. LARSEN, M.D.

The Morphology of Human Blood Cells.

By L. W. Diggs, M.D., Dorothy Sturm, and Ann Bell, B.A., 181 pp., illus. Price $12.00, W. B. Saunders Company, 1956.

This book consists of excellent colored drawings and of black and white drawings of individual cells which are found in the peripheral blood stream and in the bone marrow. Some of the drawings are textbook-like, otherwise, they are excellent. Many of us will recognize the drawings of the cells by Dorothy Sturm, which were in the issue of *Morphology of Cells* published in *What's New* by Abbott and Company.

It gives an excellent description of the morphology of normal red blood cells and white blood cells, emphasizing the characteristics of each cell, and also takes in the abnormal morphology of the erythroid and myeloid series. Plasma cells, megakaryocytes, normal and pathologic fixed tissue cells are discussed and described very well. A chapter on L. E. cells describing typical and atypical forms is well written up. There is also a chapter discussing techniques and methods which is excellent.

This book is a handy reference on morphology of cells to have in a laboratory, whether it be in a hospital laboratory, in a doctor's office, or in a medical clinic laboratory, because the colored plates of the individual cells are well presented and the descriptions of each cell are well described. It is especially valuable for the beginner.

GRACE OISHI KAGAWA, M.T.

Forceps Deliveries.

By Edward H. Dennen, M.D., 228 pp., illustrated, Price $6.50, F. A. Davis Company, 1955.

The obstetrician is confronted by a bewildering array of instruments when he asks for "forceps." This book is a valuable reference for anyone interested in the various types of forceps available and the situations in which one may be preferred to another. It is well illustrated and understandably written.

T. ROBERT WHITE, M.D.

Clinical Selections in Dermatology and Mycology.

Edited by Frederick Rehm Schmidt, A.B., M.D., 505 pp., Price $10.50, Charles C. Thomas, 1956.

Forty-three articles, by 36 contributors, mostly Latin Americans, on a variety of dermatological subjects. Of interest to dermatologists; not recommended for non-dermatologists.

HARRY L. ARNOLD, JR., M.D.

Handbook of Legal Medicine.

By Louis J. Regan, M.D. and Alan R. Moritz, M.D., 201 pp., illustrated, The C. V. Mosby Company, 1956.

Because of the paucity of information available in the field of forensic pathology, Regan and Moritz' recent small volume should be a welcome addition to the library of every careful practitioner, be he general practitioner or specialist. Within the recognized limits of the scope of this small handbook may be found many profound bits of careful advice as to how to avoid involvement in litigation and many well established but little known forensic facts. The handbook is inadequate as a source or reference book for the forensic pathologist but is an excellent introduction into the field of forensic medicine for the usual practitioner. A bibliography, other than a number of "selected references," is conspicuous by its absence and it is truthfully difficult to evaluate whether this absence adds or detracts. The very elementary nature of the handbook is emphasized by the publication of a glossary at the end of the text but elementary as the manual is, the vast majority of practitioners can learn considerable from this handbook. It is to be recommended if for no other reason than that the stature of its authors demands attention.

ALVIN V. MAJOSKA, M.D.

Progress in Hematology.

By Leandro M. Tocantins, M.D., 336 pp., illustrated, Price $9.75, Grune & Stratton 1956 (Vol. 1).

This is a collection of sixteen complete papers on the various aspects of hematology by leading authorities in the field. The presentations are orderly, concise, and informative of the progress to date in this rapidly developing facet of medicine. The bibliography is excellent. This volume is a welcome addition to our medical literature and should be of interest to clinicians as well as students.

T. F. FUJIWARA, M.D.

Also Received

New and Nonofficial Remedies, 1956.

Evaluated by the Council on Pharmacy and Chemistry, 540 pp., illustrated, J. B. Lippincott Company, 1956.

Much more inclusive and valuable under the flexible new program of evaluation.

Psychosomatic Aspects of Surgery.

Edited by Alfred J. Cantor, M.D., and Arthur N. Foxe, M.D., 220 pp., Price $6.50, Grune & Stratton, Inc., 1956.

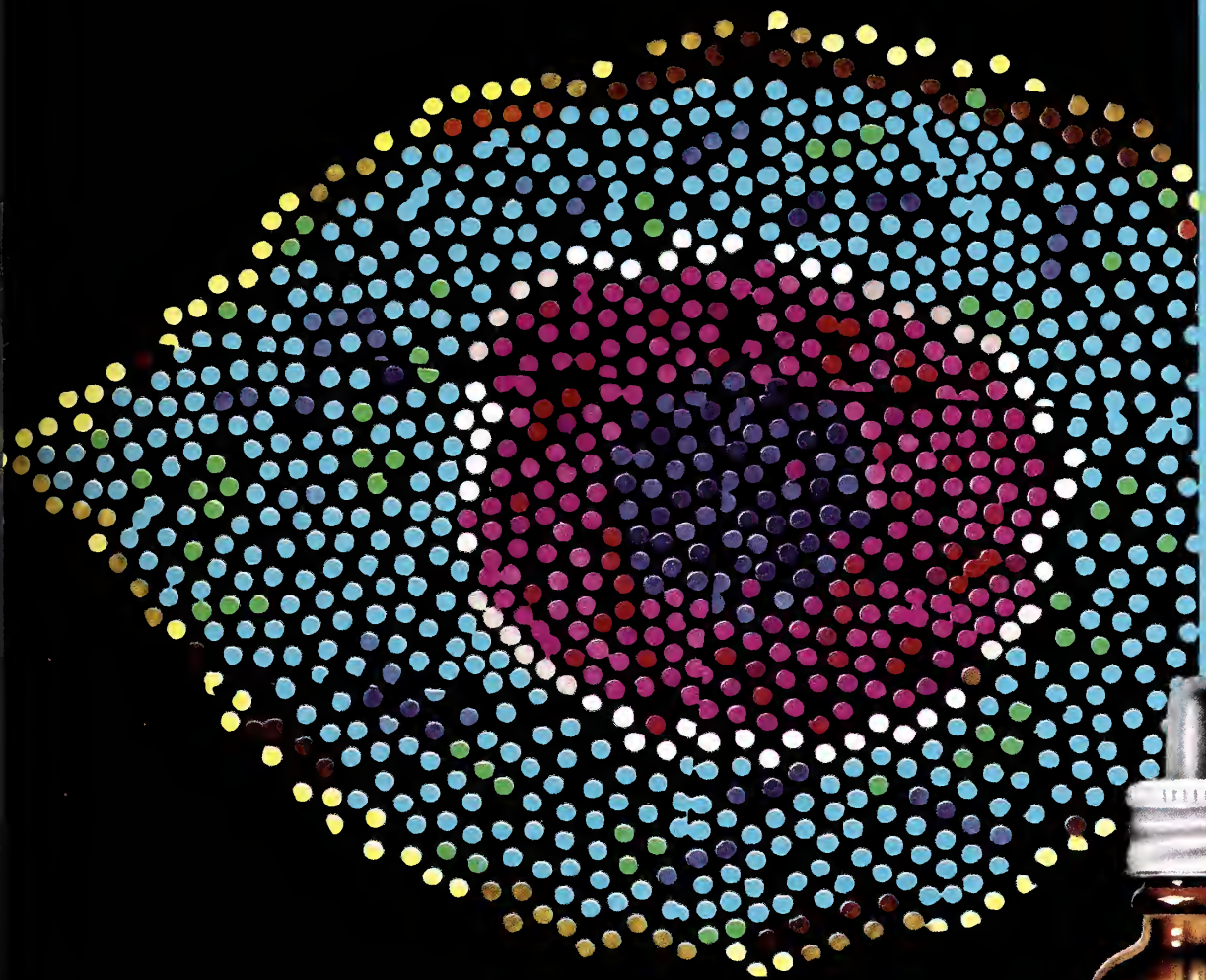
Every surgeon should read the portion of this book devoted to his particular field of surgery, and particularly the 34-page panel discussion at the end. A valuable book.

Techniques and Procedures of Anesthesia.

By John Adriani, M.D., 568 pp., illustrated, Price $8.75, Charles C. Thomas, 1956 (2d Edition).

More about anesthesiology than most physicians want to know—or need to. The outline form makes for difficult reading, but is clear, concise, and highly informative. For anesthesiologists.

(*Continued on page 100*)





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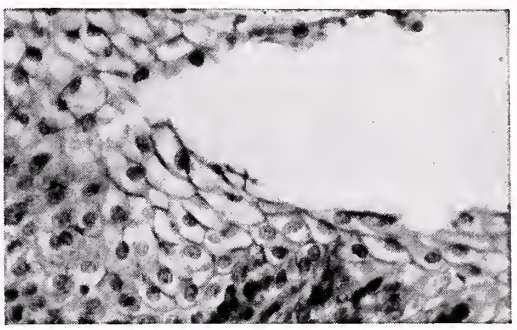
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TOO OFTEN AN ORDINARY trichomonacide fails to cure vaginal trichomoniasis because it has little or no effect on parasites that are not on the surface.[1] Trichomonads burrowed deeply into the roughened mucosa survive and set up new foci of infection. In fact, even a few hidden trichomonads remaining after treatment can cause acute exacerbations. With VAGISEC® liquid and jelly you can overcome this most troublesome problem.

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Proves highly effective — With the Davis technique† you can now rid patients of "trich," even cases that have resisted other treatment. VAGISEC liquid was developed as "Carlendacide," by Dr. Carl Henry Davis, M.D., noted gynecologist and author, and C. G. Grand, research physiologist.[1] Clinical trials by more than 150 physicians show better than 90 per cent success.[3]

Use liquid and jelly — In the Davis technique, VAGISEC liquid is used in office therapy. At the same time, liquid and jelly are prescribed for home use. They are well tolerated, leave no messy discharge or stain.

Office treatment — Expose vagina with speculum and wipe walls dry with cotton balls. Then wash thoroughly with a 1:100 dilution of VAGISEC liquid. Remove excess fluid with cotton balls. Dr. Davis recommends six treatments.

Home treatment—Patient douches with VAGISEC liquid every night or morning and then inserts VAGISEC jelly. Home treatment is continued through two menstrual periods, but omitted on office treatment days. Douching contraindicated in pregnancy.

One course of treatment—"If the treatment has been accomplished as directed," the patient "will have no flagellates provided the infection was limited to the vaginal canal . . . A few women have infected cervical, vestibular or urethral glands and require other types of treatment."[4] Continued douching with VAGISEC liquid two or three times each week for eight to twelve weeks helps prevent re-infection.

Prevents coital re-infection — Infected husbands are ". . . a potential source of re-infection in wives successfully treated."[5] Prescribe for your patients the protection afforded by Schmid high quality condoms. Specify the superior RAMSES® rubber prophylactic, transparent, tissue-thin, yet strong. If there is anxiety that rubber might dull sensation, prescribe XXXX (FOUREX)® prophylactic skins, of natural animal membrane, pre-moistened.

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References: 1. Davis, C. H., and Grand, C. G.: Am. J. Obst. & Gynec. 68:559 (Aug.) 1954. 2. Davis, C. H.: J.A.M.A. 157:126 (Jan. 8) 1955. 3. Davis, C. H.: West. J. Surg. 63:53 (Feb.) 1955. 4. Davis, C. H. (Ed.): Gynecology and Obstetrics (revision), Hagerstown, W. F. Prior, 1955, vol. 3, chap. 7, pp. 23-33. 5. Lanceley, F., and McEntegart, M. C.: Lancet 1:668 (Apr. 4) 1953.

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Erythromycin in the treatment of osteomyelitis*

8/3/55

CASE SUMMARY

On 6/2/55, patient, male, age 28, fell on an old fracture and refractured the middle third of the right femur, superimposed on an old osteomyelitis.

On 7/7/55, the wound was saucerized and a hemolytic S. aureus (coag. +) was isolated from the osteomyelitis. Disc sensitivities were: penicillin, 10 units; erythromycin, 10 mcg.; tetracycline, 10 mcg.

On 7/15, the patient was placed on erythromycin therapy 400 mgm. q. 6. h. Patient afebrile after erythromycin started. X-rays showed evidence of healing with callus formation. No septicemia and clinical evidence indicates control of the infection.

On 8/3, the cast was removed and leg recast. Wound was in good condition with minimal drainage.

Diagnosis: fracture middle third of right femur, complicated by osteomyelitis.

Result: erythromycin aided healing of the old osteomyelitis and kept the infection under control.

* *Communication to Abbott Laboratories*

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BOOK REVIEWS

(*Continued from page 96*)

Histamine.

Ciba Foundation, 472 pp., illustrated, Price $9.00, Little, Brown and Company, 1956.

An authoritative symposium and a highly valuable reference work.

Pediatric Proctology.

Pediatric Clinics of North America, 220 pp. illustrated, W. B. Saunders Company, 1956.

Proctologists and pediatricians cannot afford to miss this issue.

The Menninger Story.

By Walker Winslow, 350 pp., Price $5.00, Doubleday & Company, Inc., 1956.

A psychiatric epic of interest alike to laymen and physicians.

Medical Writing No. 2.

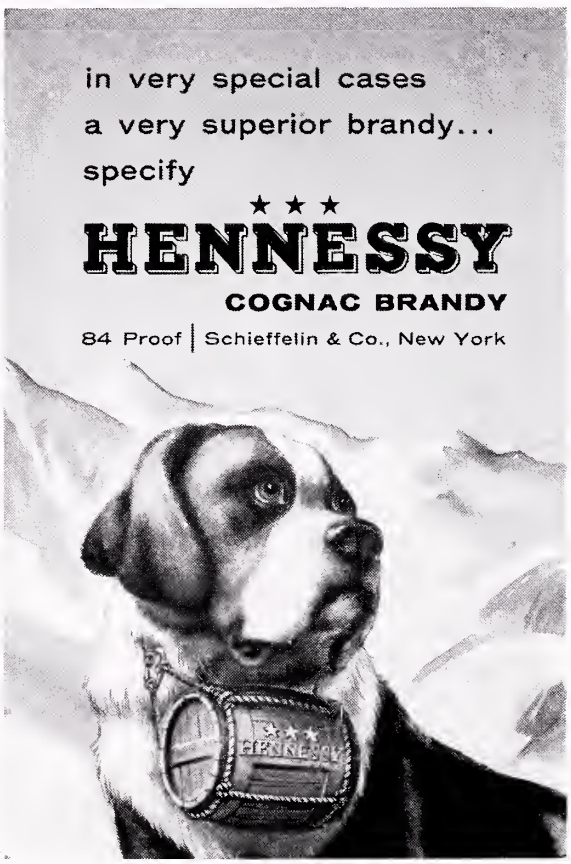
International Symposia, 66 pp., illustrated, MD Publications, Inc., 1955.

Five practical and highly valuable essays which no medical writer or editor can afford to miss.

The Surgical Clinics of North America.

New York Number, April 1956, pp. 255-553, Figs. 61-155, W. B. Saunders Company.

A New York symposium on all new adjunctive measures in surgery.



Progress in Psychotherapy.

Edited by Frieda Fromm-Reichmann, M.D., and J. L. Moreno, M.D., 352 pp., Price $8.50, Grune & Stratton, 1956.

A symposium on four varied aspects of psychotherapy.

A New Psychotherapy in Schizophrenia.

By Marguerite Sechehave, 199 pp., Price $4.50, Grune & Stratton, 1956.

For psychiatrists only.

Physical Diagnosis.

By Ralph H. Major, M.D., and Mahlon H. Delp, M.D., 358 pp., illus., Price $7.00, W. B. Saunders Company (5th edition) 1956.

Primarily for students, although the historical allusions make it of more than ordinary interest. Not very carefully edited.

The Recovery Room—Immediate Postoperative Management.

By Max S. Sadove, M.D., and James H. Cross, M.D., 597 pp., illus., Price $12.00, W. B. Saunders Co., 1956.

Two Chicago surgeons and twenty-four additional contributors discuss the surgical recovery room from every imaginable standpoint. Of great interest to hospital administrators and surgeons.

Psychoanalysis of Behavior.

By Sandor Rado, M.D., D.P.Sc., 387 pages, Price $7.75, Grune & Stratton, Inc., 1956.

Pretty deep and philosophical. For psychiatrists only.

Virus Diseases and the Cardiovascular System.

By Ernest Lyon, M.D., 215 pp., Price $5.75, Grune & Stratton, Inc., 1956.

Every cardiologist should own this book and it would be of great interest to neurologists, pediatricians, and internists particularly. Highly recommended by Paul D. White, M.D.

The Office Assistant.

By Portia M. Frederick and Carol Towner, 351 pp., illustrated, W. B. Saunders Company, 1956.

Everything your office girl would possibly need to know.

Changing Concepts of Psychoanalytic Medicine.

Edited by Sandor Rado, M.D., and George E. Daniels, M.D., 248 pages, with charts, Price $6.75, Grune & Stratton, Inc., 1956.

A collection of essays based on papers read at Columbia University in March 1955. Important for psychiatrists.

Cryptococcosis.

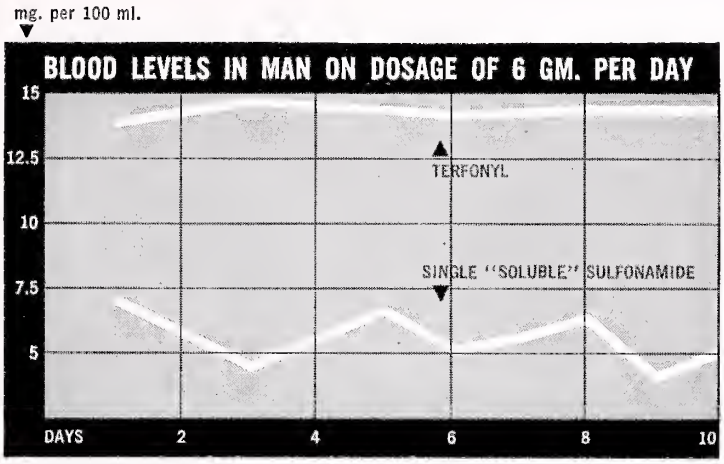
By M. L. Littman, M.D., and Lorenz E. Zimmerman, M.D., 205 pages, illus., Price $8.50, Grune & Stratton, Inc., 1956.

Beautifully printed, liberally illustrated with spectacular color plates, well indexed, authoritative and readable account which tells far more about cryptococcosis than most doctors want to know. An indispensable reference work.

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— After Lehr, D., Modern Med. 23:111 (Jan. 15) 1955.

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(1) Crenshaw, J. F.: Am. J. Digest. Dis. *17*:387, 1950. (2) Lichtman, S. S.: Diseases of the Liver, Gallbladder and Bile Ducts, ed. 3, Philadelphia, Lea & Febiger, 1953, vol. 2, p. 951. (3) Sherlock, S.: Diseases of the Liver and Biliary System, Springfield, Charles C Thomas, 1955, p. 642. (4) King, J. C.: Am. J. Digest. Dis. *22*:102, 1955.

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Pediatric Bibliography

1. Wikler: The Use of Chlorpromazine as an Anti-emetic in Children, Arch. Pediat. *72*:197 (June) 1955.
2. Daeschner et al.: Chlorpromazine in the Control of Vomiting in Children, Am. J. Dis. Child. *89*:525 (May) 1955.
3. Steigman and Vallbona: Chlorpromazine, A Useful Antiemetic in Pediatric Practice, J. Pediat. *46*:296 (March) 1955.
4. Steigman and Vallbona: Experience with Chlorpromazine in Pediatrics, Internat. Rec. Med. & Gen. Pract. Clinics *168*:351 (May) 1955.
5. Moyer et al.: Clinical Studies of an Anti-emetic Agent, Chlorpromazine, Am. J. M. Sc. *228*:174 (Aug.) 1954.

*T.M. Reg. U.S. Pat. Off.

Smith, Kline & French Laboratories, Philadelphia

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1956-1957

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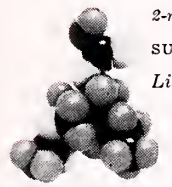
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1. Cronheim, G., and Toekes, I. M.; Comparison of Sedative Properties of Single Alkaloids of Rauwolfia and Their Mixtures, Meet. Am. Soc. Pharmacol. & Exper. Therap., Iowa City, Iowa, Sept. 5, 1955.

2. Moyer, J. H.; Dennis, E., and Ford, R.: Drug Therapy (Rauwolfia) of Hypertension. II. A Comparative Study of Different Extracts of Rauwolfia When Each Is Used Alone (Orally) for Therapy of Ambulatory Patients with Hypertension, A.M.A. Arch. Int. Med. *96*:530 (Oct.) 1955.

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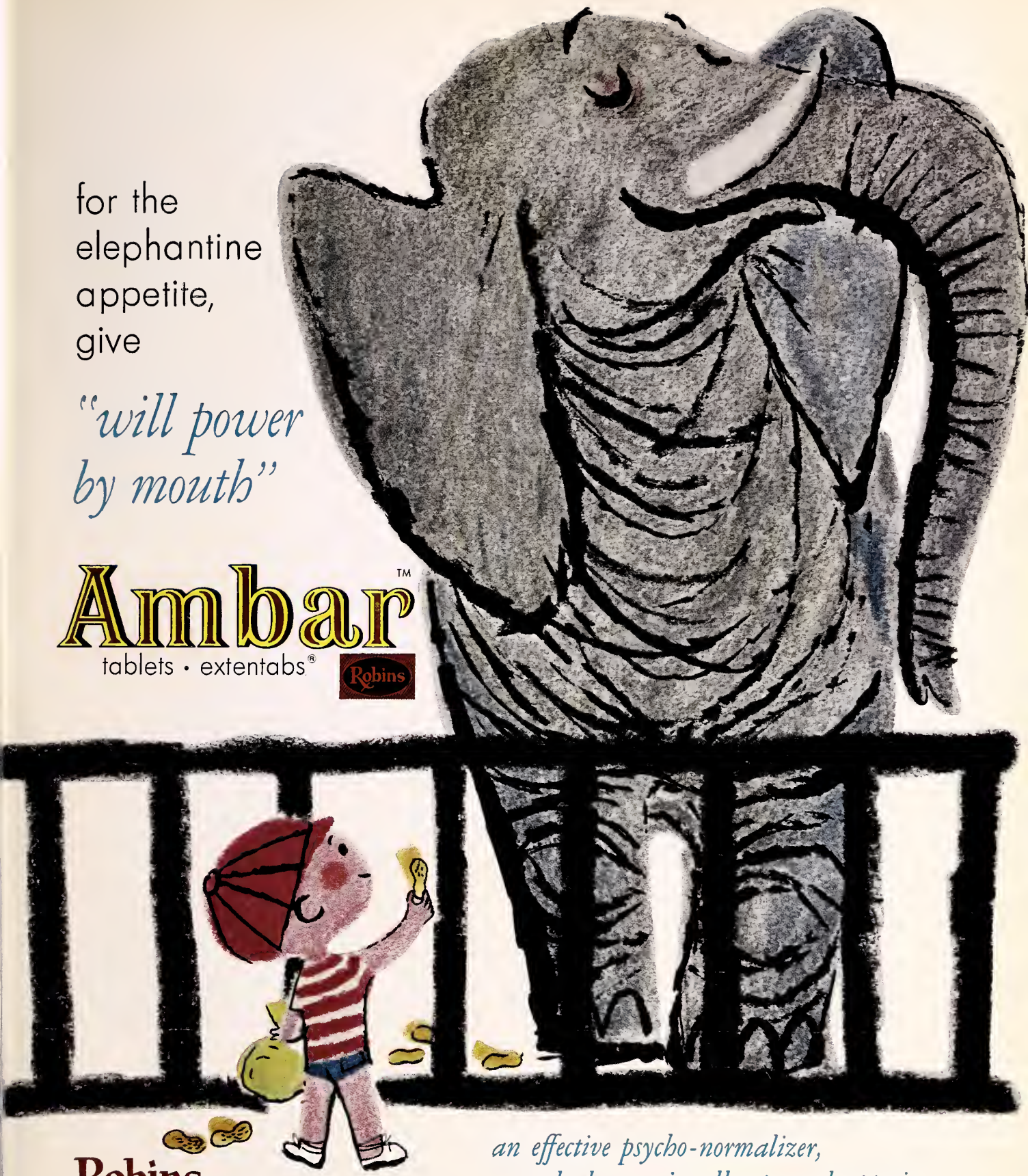
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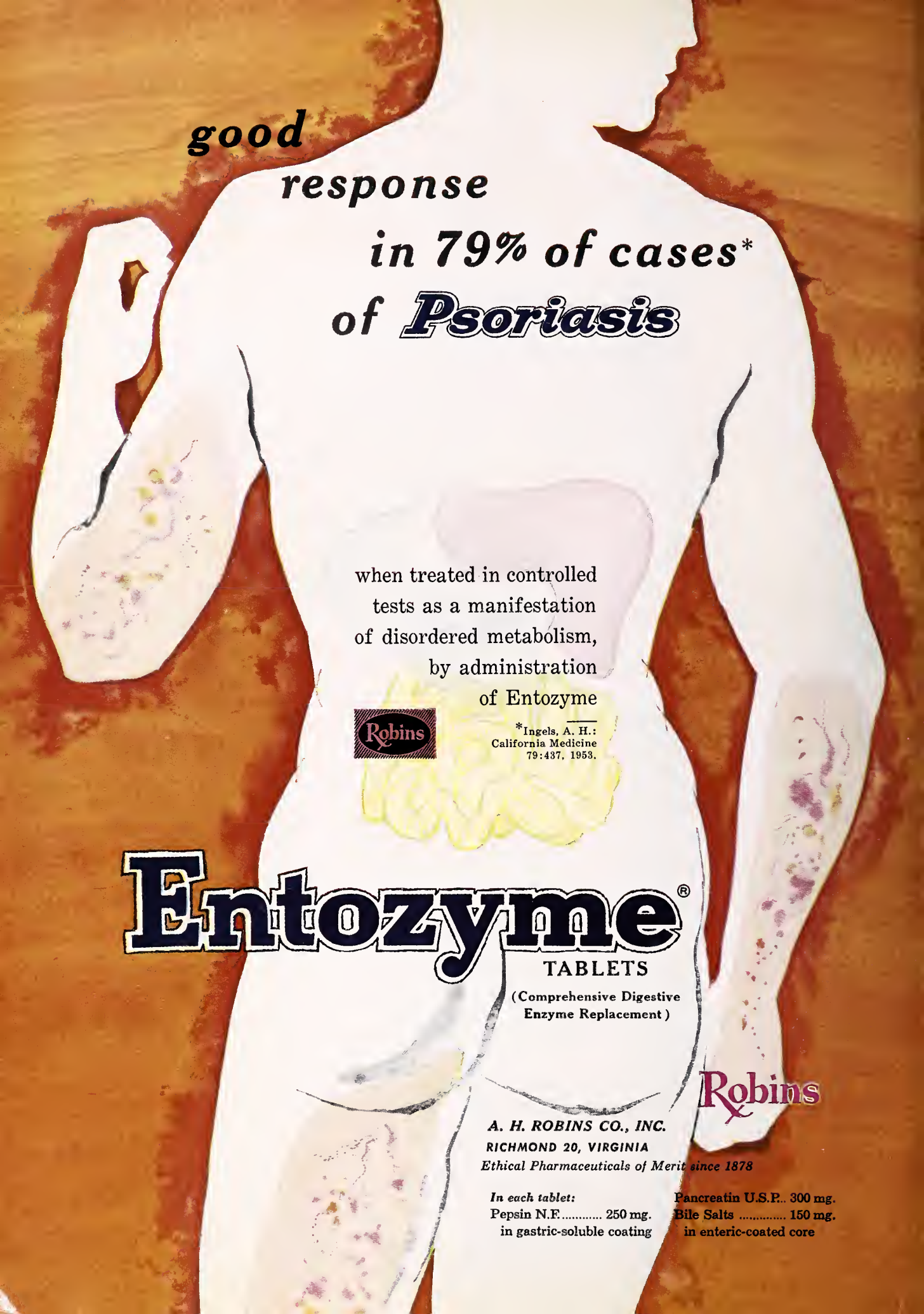
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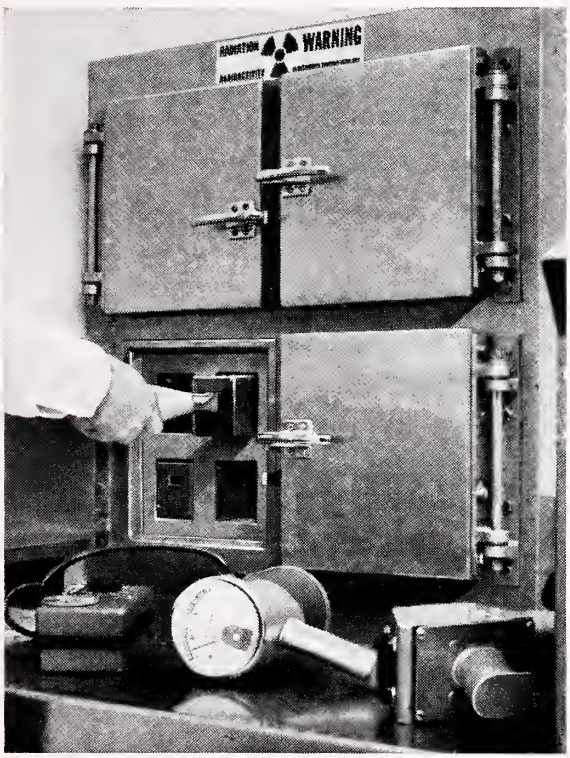
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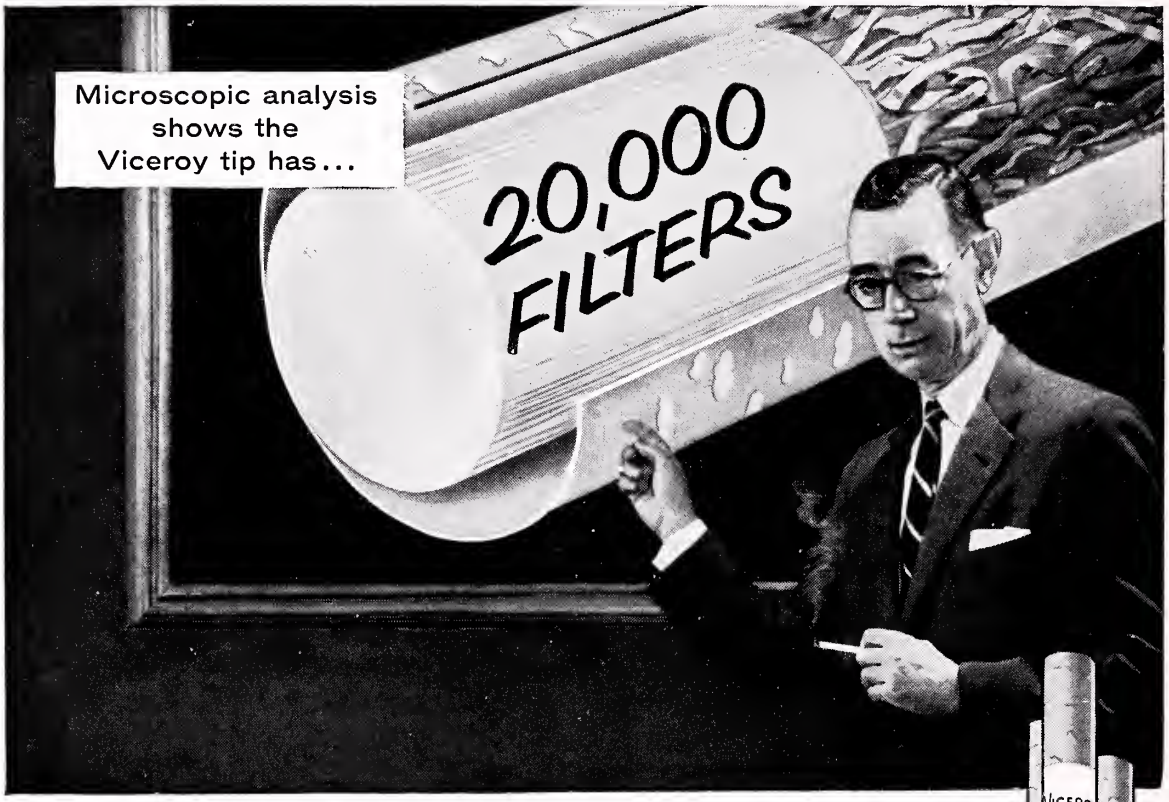
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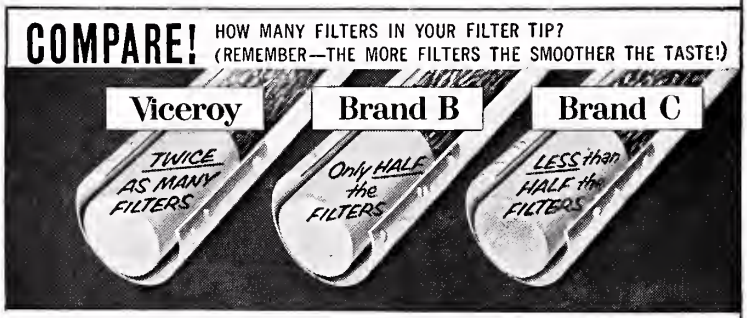


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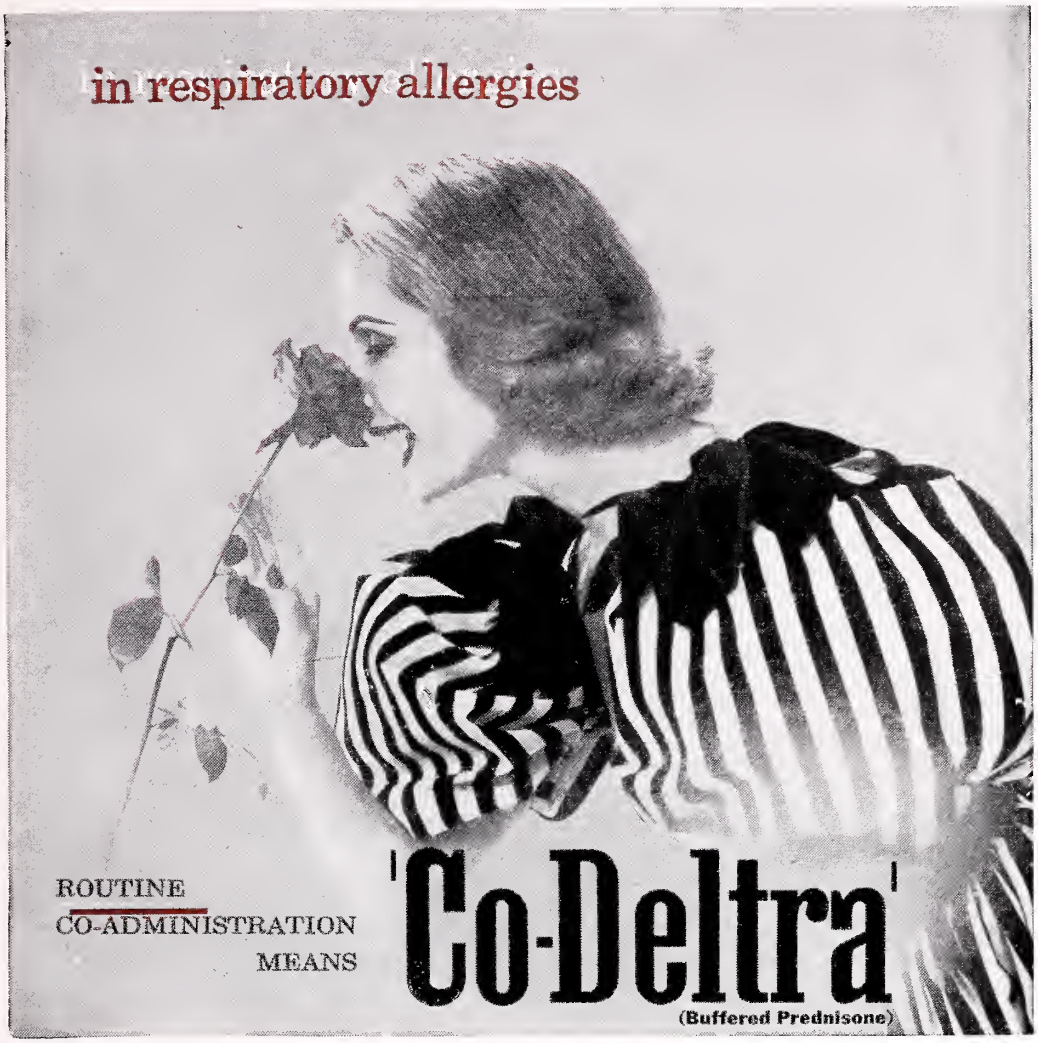
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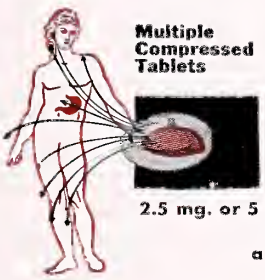
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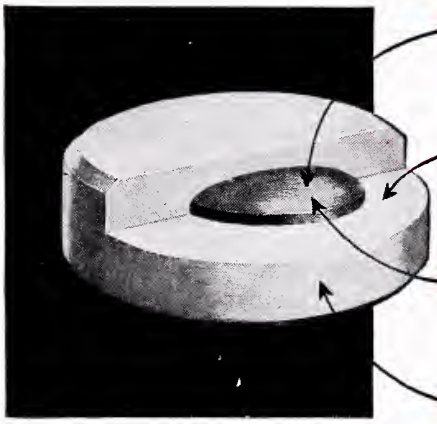
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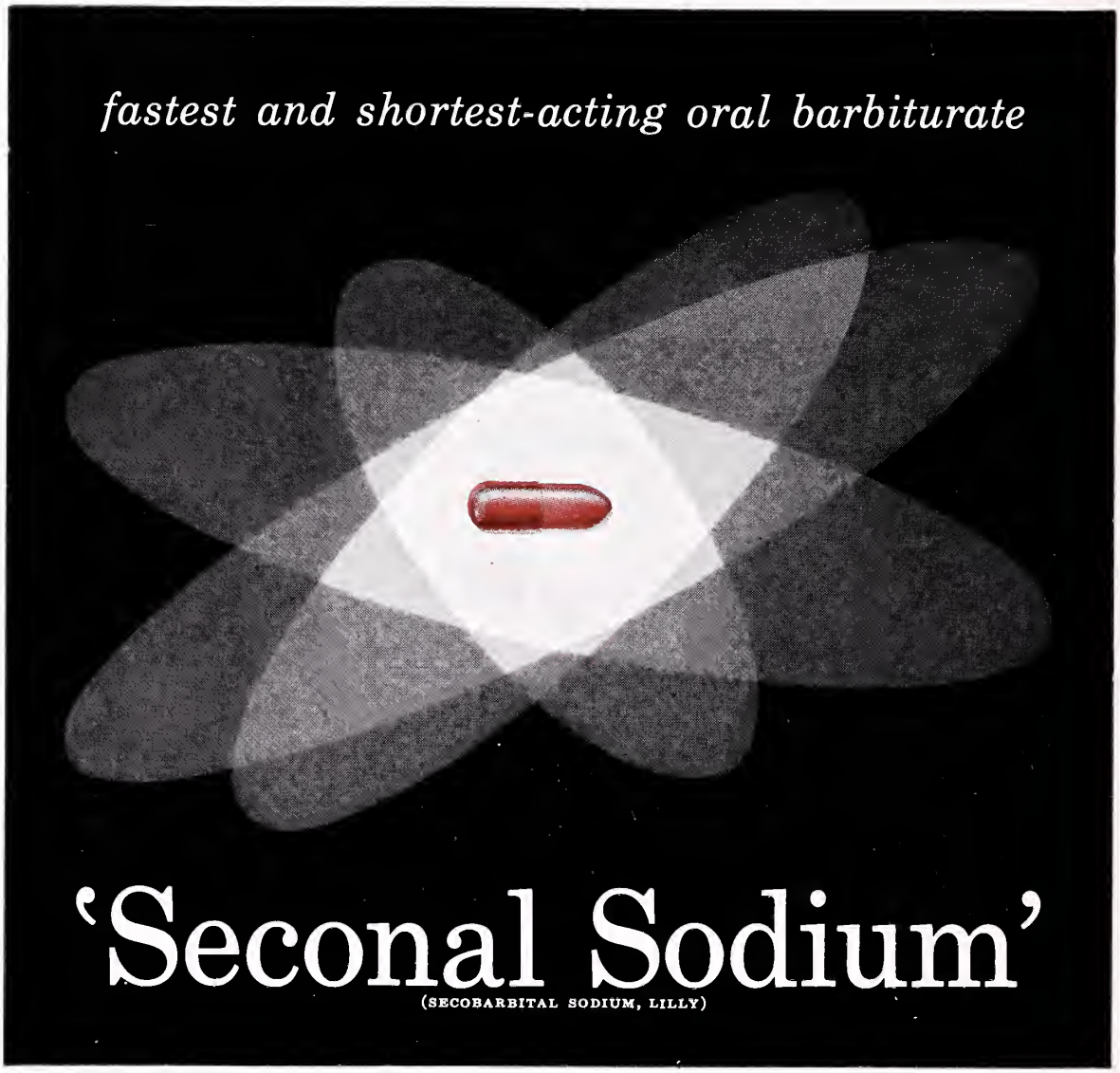
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RACIAL ASPECTS OF LEPROSY AND RECENT THERAPEUTIC ADVANCES

EDWIN K. CHUNG-HOON, M.D.,* and GRACE HEDGCOCK, M.D.,† Honolulu

In the past decade 271 new cases of leprosy have been diagnosed in Hawaii, slightly under half of them in Hawaiians and part Hawaiians, and one-fourth in immigrant Filipinos. Lowest morbidity is in Japanese. One-fourth of new cases are released after six months' treatment, four-fifths after two years', as a result of sulfone therapy.

RECORDED in the pages of time is a disease that maims the human body by primarily attacking its nervous and cutaneous structures. It produces granulomatous changes in the peripheral nerves with resultant anesthesia, paralysis, atrophy and ultimate absorption of the vital tissues those nerves supply. It produces lesions of the cutaneous surface that simulate almost any type of dermatosis. This is the disease of antiquity . . . leprosy, which some prefer to call Hansen's disease.



DR. CHUNG-HOON

It is a neurocutaneous disease caused by Mycobacterium leprae, which morphologically and by its staining characteristics resembles the Mycobacterium of tuberculosis. While they look alike in their bacterial features and color the former enjoys a habitat of nerve and skin structures, while the latter prefers to establish pathological changes in the lungs and other viscera. The Mycobacterium of leprosy, discovered by Dr. G. Armauer Hansen of Norway in 1874, has defied all attempts at cultivation on artificial media and it has to this date been reluctant to produce the manifestations of leprosy in lower animals. And yet with the greatest of ease, one may recover an abundance of them from cutaneous lepromas, which are always extremely rich in these acid-fast bacilli.

Leprosy invades the eye, scars its cornea and blinds some of its victims. Its granulomatous infiltrate spreads throughout the mucous membranes of the nose, larynx and tracheobronchial tree, destroying important structures in these areas, to end in cicatricial contractures of the nasal passages, larynx and mouth. Peripheral nerve involvement produces enlargement of nerves the like of which is not seen or palpated in any other disease. The nerve lesion is a perineural granulomatous infiltration which causes the nerve cord to become thick and nodulated. Pressure of this granulomatous tissue ultimately destroys the nerve fibrils, and neurotropic changes result to produce deformities and mutilations, especially of the face, hands and feet.

The dermatological lesions of this strange disease simulate in brilliance and design the architectural patterns of lesions of common dermatoses ranging from the hypopigmented spots of Hawaii's tinea versicolor, the wheals of urticaria, the maculopapules of pityriasis rosea and the scaly papules of psoriasis to the nodular lesions of syphilis, the indolent nodular lesions of tuberculosis cutis and the infiltrated lesions of lymphoblastoma of the skin.

With the passage of time we have come to recognize leprosy as an intriguingly interesting disease that rivals systemic lupus erythematosus and syphilis in the fascination it offers to all of us in every branch of medicine. Its manifestations are as protean as those of syphilis.

One of the elements in the theme of this Centennial Convention is "race and its connection with disease." Hawaii's leprosy story contains an interesting chapter on this subject. While little is known of the actual status of the disease 100 years ago, the first tabulation of Hansen's disease was made 90 years ago, in 1866, and the count for that year was 141 new cases of which 139 were Hawaiians and 2 were Chinese. While leprosy has been called by many names, its earliest name in Hawaii was "*mai Pake*" or "Chinese sickness." It is presumed that the early Chinese immigrants had brought the disease from their endemic homeland to this non-leprous Territory. With a population of people relatively unexposed to civilization's maladies it was not surprising that the Hawaiian was to become the chief ethnic group involved with leprosy, and he has supplied most of

Read at the Centennial Meeting of the Hawaii Medical Association, April 27, 1956.
From the Department of Health, Territory of Hawaii.
* Chief of Hansen's Disease Medical Service.
† Medical Director, Hale Mohalu Hospital.

the cases of this disease up until recent years. As the population of Hawaii became diluted with ethnic groups from various parts of the world the pendulum has gradually swung to the opposite side, and today one sees less than half of the new cases in the Hawaiian ("residents") and more than half occuring in other races ("newcomers").

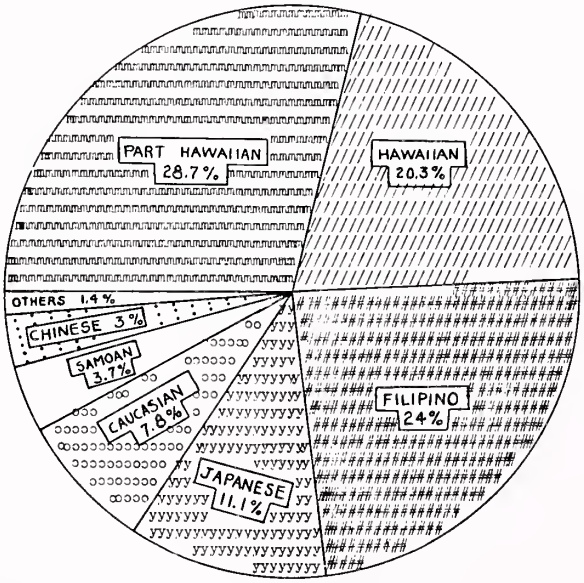
Racial Distribution of New Cases

TABLE 1.—*Racial Distribution of 271 New Cases.*

RACE	1946-1951	1951-1956	10 YR. TOTAL
Part Hawaiian	53	25	78
Hawaiian	29	26	55
Filipino	39	26	65
Japanese	18	12	30
Caucasian	13	8	21
Chinese	3	5	8
Samoan	1	9	10
Korean	1	1	2
Others	0	2	2
Total	157	114	271

For this report we have chosen to discuss the new cases certified during the past 10 years. In the decade 1946-1956 there were 271 new cases added to the Hansen's disease registry. In this total figure Hawaiians accounted for 55 cases (20.3%) and part Hawaiians 78 cases (28.7%). If we may be permitted to combine these two categories who have the same ethnological qualities into one, the "resident group," and all others into the "group of newcomers" the tally would show that leprosy in Hawaii is becoming an "alien disease" with 49% of the new cases supplied by the "resident group" and 51% occurring in the "newcomers." This is a striking reduction in the incidence from 98% in 1866 alone. It is also significant that 24% of the new cases occurred in Filipinos, most of whom were born and reared in the Philippine Islands.

GRAPH 1.—*Distribution of 271 New Cases by Race, 1946-1956.*



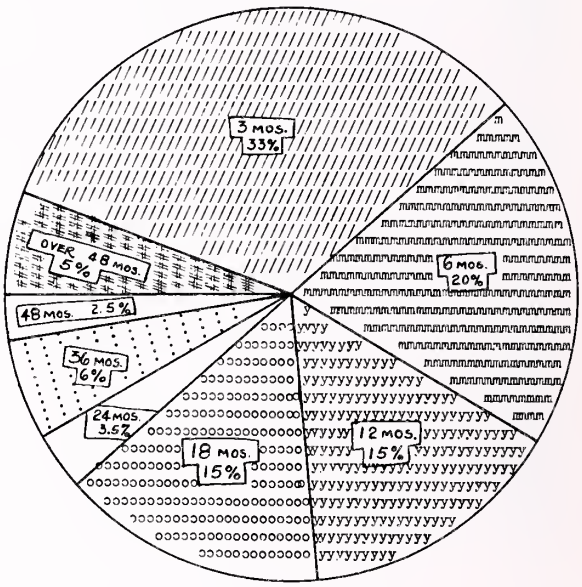
Morbidity Rate by Race

TABLE 2.—*10 Year Average Morbidity by Race, 1946-1956.*

RACE	RATE PER 100,000 PER YEAR
Part Hawaiian	10.6
Hawaiian	45.4
Filipino	17.0
Japanese	1.6
Caucasian	2.2
Chinese	2.5
Korean	3.1
Samoan and Others	9.4

While the Hawaiian group accounted for only 55 of the 271 cases, its morbidity rate of 45.4 (cases per 100,000) is higher than any of the other ethnic groups. The Japanese, with a seemingly high number of cases (30) have the lowest morbidity rate, 1.6.

GRAPH 2.—*Duration of Symptoms, All Races, 1946-1956.*



Race and Bacterioscopy

TABLE 3.—*Race and Bacterioscopy.*

RACE	POSITIVE FOR AFB	NEGATIVE FOR AFB
Part Hawaiian	50	28
Hawaiian	29	26
Filipino	33	32
Japanese	15	15
Caucasian	10	11
Chinese	3	5
Korean	1	1
Samoan	7	3
Others	2	0
	150 (55.4%)	121 (44.6%)

In the survey it was noted that 54.4% of the patients were in the communicable stage with positive bacteriologic findings, and had to be isolated, while 45.6% had negative bacteriologic examinations and could be treated as outpatients. If the new patient with leprosy was a Hawaiian, a Caucasian, a Japanese, a Korean or a Filipino

he had a fifty-fifty chance of being treated as an outpatient. On the other hand if he were of part Hawaiian or Samoan ancestry the chances were nearly two to one that he had to be isolated for care and treatment.

Race and Sex

TABLE 4.—*Race and Sex and Ratio of Males/100 Females.*

RACE	MALES	FEMALES	MALES PER 100 FEMALES
Part Hawaiian	47	31	152
Hawaiian	28	27	104
Filipino	62	3	2067
Japanese	18	12	150
Caucasian	10	11	91
Chinese	7	1	700
Korean	1	1	100
Samoan	6	4	150
Others	1	1	100
Total	180	91	

Among all races in Hawaii, leprosy affected twice as many males as females. This is a fairly stable ratio the world over. By race the sex ratio varied from 91 to 2067 per 100 females. The high male ratio of 20:1 occurred in the Filipino group, which has a higher proportion of males in the Territory.

Race and Duration of Disease

TABLE 5.—*Race and Duration of Disease.*

RACE	HISTORY OF DURATION OF MANIFESTATIONS IN MONTHS								
	3	6	12	18	24	36	48	OVER 48	TOTAL
Part Hawaiian	25	11	13	13	3	6	3	4	78
Hawaiian	15	13	8	10	2	3	2	2	55
Filipino	20	13	7	12	2	6	1	4	65
Japanese	12	7	3	5	0	1	0	2	30
Caucasian	8	2	7	0	1	1	1	1	21
Chinese	1	5	1	0	1	0	0	0	8
Korean	1	1	0	0	0	0	0	0	2
Samoan	6	2	1	1	0	0	0	0	10
Others	2	0	0	0	0	0	0	0	2
Total	90	54	40	41	9	17	7	13	271

It seems that the Hawaiian, part Hawaiian and the Filipino were less prone to seek an early diagnosis, while the Orientals were among those who desired to know the nature of their illness as soon as possible. All of the Korean cases were diagnosed within 6 months after the appearance of the lesions of leprosy. For all races the survey showed that 68% of cases gave a history of having had manifestations for 12 months or less.

Sulfone Treatment

Prior to 1946 leprosy's treatment consisted in



FIG. 1 (Case No. 4076).—Part Hawaiian, age 40, before sulfone (Promacetin) therapy presenting generalized nodular eruption of lepromatous leprosy, acid-fast bacilli (4 plus) and negative lepromin test.



FIG. 2 (Case No. 4076).—After two years of continuous sulfone (Promacetin 1778.0 grams) therapy, lepromas have disappeared, cutaneous surface is clear, but acid-fast bacilli are still present (2 plus).

Hawaii of chaulmoogra oil and sanatorial care, and the leprous patient led a not-too-hopeful existence in the Territory's leprosaria. Only those who were negative bacteriologically throughout their disease ever became eligible for release from the hospital. Those who were positive for acid-fast bacilli never seemed to be able to reach the stage of non-communicability that would permit their release from isolation. The disease progressed slowly but persistently to destroy bit by bit the patient's important structures; to cripple his hands and feet; to mar his features; to often cause blindness; and then ultimate death. The leprous patient, swathed in bandages and spotted with 40 or 50 Band-aids, was a familiar sight in Hawaii's leprosy settlements.

The year 1946 marks a milestone in Hawaii's leprosy story, for at the commencement of that year a new approach to therapy was achieved. It was inevitable that the amazing discoveries of the World War II era would offer benefits in the therapeutic realm of leprosy. Out of the maze of discoveries came Promin, Diasone, Promizole, Promacetin and diaminodiphenylsulfone—potent drugs of the sulfone family. Though the sulfonamides, the penicillins and the mycins all have a beneficial effect in clearing up intercurrent infection in the Hansen's disease patient, some of them seemed to have as spectacular effects upon the lesions of leprosy as did Promin and the other sulfones.

Promin is given intravenously in daily doses of 1 to 5 grams; Diasone is given orally in the daily dosage of 0.3 to 1.2 grams; Promacetin 0.5 to 4.0 grams; diaminodiphenylsulfone 0.1 gram; and Promizole is given in daily dosages of 5 to 10 grams, orally. Because of its expense and because the patient has to take such huge amounts of the drug to get the same benefit as the other sulfones produce in smaller dosages, Promizole is not widely used here.

The beneficial effects from these drugs are noticed almost immediately by the patient. The generalized malaise and weakness from months to years of infection with a chronic debilitating disease rapidly give way to a general feeling of well-being. Appetites pick up; weight gains are noticeable; and above all the leprous patient appreciates the restful sleep he can now have.

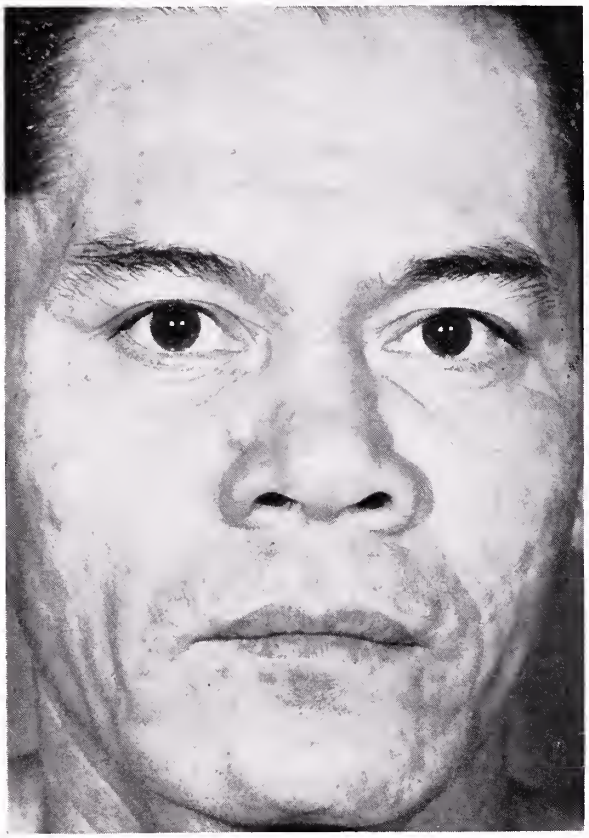


FIG. 3 (Case No. 4096).—Filipino, age 44, before sulfone (Promacetin) therapy presenting generalized nodular eruption of lepromatous leprosy, acid-fast bacilli 4 plus and negative lepromin test.

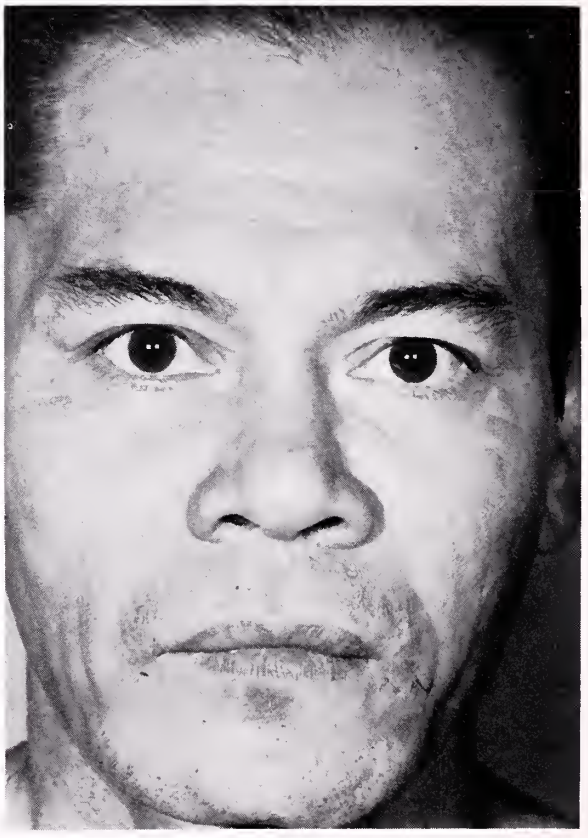


FIG. 4 (Case No. 4096).—After one year of continuous sulfone (Promacetin 919.0 grams) therapy, lepromas have disappeared, cutaneous surface is clear, but acid-fast bacilli are still present (2 plus).



FIG. 5 (Case No. 4099).—Part Hawaiian, age 42, before sulfone (Diasone) therapy exhibiting huge leproma of glabella and diffuse "puffy" facial infiltration of lepromatous leprosy, acid-fast bacilli 4 plus, negative lepromin test.

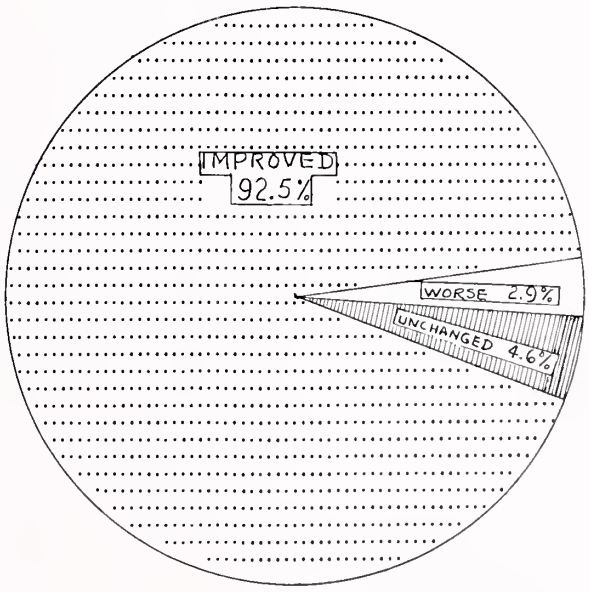


FIG. 6 (Case No. 4099).—After one year of continuous sulfone (Diasone 64.95 grams) therapy, shows marked regression of leproma of glabella and clearing of facial lepromatous infiltration; acid-fast bacilli 3 plus.

Within 3 months of treatment definite objective signs of improvement are noticeable. The heavy lepromatous tumors of the skin flatten out and the ulcerations of the skin and mucous membranes heal to solid scars where formerly irrespective of any form of treatment they remained as open, draining sores of months' to years' duration.

Leprosy is a relapsing disease with periods of quiescence and reactivity. During the relapses the patients suffer fever, excruciating neuritic pain along the course of affected nerves, renewed activity in old lepromas and the appearance of new acutely inflamed leprous infiltrations. Such lepromatous reaction lesions often occur in the mucous membranes of the tracheobronchial tree, and particularly in the larynx. When such occurs, laryngeal obstruction is the result, and tracheotomies were necessary in many of the patients prior to 10 years ago. Since the advent of sulfone therapy, however, few severe leprous reactions of this nature were noted in the 271 patients included in this survey, and only one required a tracheotomy.

GRAPH 3.—*Results of Sulfone Treatment of 271 New Cases, 1946-1956.*



In addition to the clinical improvement, there is a concomitant reduction in the numbers of bacilli in the lesions of the skin and mucous membranes. Although the clinical improvement is often dramatic, the bacilli do not disappear as rapidly. In most of the cases who had a great abundance of acid-fast bacilli it required 2 to 8 years of constant treatment to render such patients bacteriologically negative. As the bacillary count became reduced one noticed that the bacilli stained poorly and appeared fragmented and granular.

As with all medications, there are good effects and harmful effects. Sulfones have a deleterious action on the hematopoietic system. They cause destruction of blood corpuscles and interfere with the formation of hemoglobin. It is necessary therefore to study blood counts on all patients at frequent intervals to discover any tendencies to anemia. These drugs sometimes cause hemorrhagic nephritis but, interestingly, no crystalluria. With judicious administration of the drugs, prudent management of the patient and the administration of antianemic medicines, the harmful effects are minimized or entirely eliminated.

In the past decade 239 of the 271 new patients were treated with sulfones and 221 or 92.5% improved with treatment. Eleven or 4.6% remained unchanged by therapy and seven or 2.9% became worse. Of the seven patients who became worse, five exhibited sensitivity to sulfones; one had a progressive indeterminate form of the disease that did not respond to sulfones; and another had an idiosyncrasy to sulfones, developing a fatal aplastic anemia.

Of the 239 sulfone-treated cases 79 were treated in the Health Department's outpatient clinics while 160 were treated in the department's hospitals. Of the 160 hospitalized cases receiving chemotherapy, 67 or 42% became bacteriologically negative and clinically quiescent, and were ultimately discharged from the hospital to return home. The hospital stay for the 67 patients varied from six months to nine years of continuous treatment. Nearly 25% of the cases were released after six months of treatment. By the end of two years nearly 60% of the cases had been discharged. No other medication has ever approached the efficiency of these new chemotherapeutic agents in reversing such heavily positive cases of Hansen's disease.

Young Hotel Bldg.

EFFECT OF RACE, DIET, AND CLIMATE ON CARDIOVASCULAR DISEASE

KAARE RODAHL, M.D.*

I AM extremely grateful for this opportunity to exchange with our colleagues here in Hawaii information and views pertaining to the effects of race, diet and climate on the manifestations of disease. We all realize that Hawaii, with its population representing a great many countries and various races, offers an excellent opportunity for research in this field, and many of us have followed with great interest the important contributions which have already appeared from here along these lines.



DR. RODAHL

The USAF Arctic Aeromedical Laboratory in Alaska, which I represent, is also concerned with many aspects of Geographical Medicine. Alaska, like Hawaii, offers a unique opportunity for studies of the effects of climate, race and diet on the manifestations of disease and pathophysiological processes. Within the territory of Alaska, we have access to a variety of different races and ethnic groups such as the coastal and inland Eskimo, the Aleuts, the Indians, Negroes, and Whites living on different diets and under widely different environmental conditions: the southern coastal regions, the interior, the large mountain ranges, the Tundra and the Arctic coast.

Our laboratory is concerned with problems within the medical and related sciences, affecting the health and combat efficiency of military personnel engaged in Arctic operations.

It is clearly realized that the etiology, prophylaxis, and treatment of cardiovascular disease is an important military health problem.[1] This problem is of special importance to the Air Force, where the ever-increasing stresses of modern flying are superimposed on the stresses of normal living. There the processes of cardiovascular aging become important as a factor limiting the length of service of flying personnel.

Eskimos appear to be an exception to the general rule that a high animal fat diet leads to early atherosclerosis. Perhaps their moderate caloric intake, low salt intake, serene disposition, and general physical fitness account for this. Studies are still in progress.

An amazingly high incidence of atherosclerosis has been demonstrated among young American men.[3] These figures are in striking contrast to the apparently low incidence of coronary artery disease in Orientals,[4] and the reported low incidence of cardiovascular disease in the Eskimos.[6]

It has repeatedly been pointed out that the differences which exist among peoples in incidence and severity of atherosclerosis tend to correlate with culturally-conditioned variations in nutrition and diet, rather than with racial, climatic or other factors.[7] Further impressive evidence to this effect has been presented by Larsen.[5]

Numerous reports indicate that low dietary intakes of animal fat are associated with low incidence of atherosclerosis.[4] In view of the fact that the Eskimo race was generally believed to have a low incidence of cardiovascular disease,[6] although the diet was apparently high in fat and cholesterol, we made a preliminary survey of four different groups of Eskimos in Alaska during a two-year period. We found by routine clinical examination

Read at the Centennial Meeting of the Hawaii Medical Association, April 23, 1956.

* Director of Research, Arctic Aeromedical Laboratory.

[1] Milch, L. J.: Military Aspects of Coronary Artery Disease. Mil. Surg. 114:333 (May) 1954. Page.[2]

[2] Page, I. H., et al.: Symposium on Atherosclerosis. Publ. 338, Nat. Academy of Sciences—Nutritional Research Council, 1954.

[3] White, N. K., Edwards, J. E., and Dry, T. J.: Relationship of Degree of Coronary Atherosclerosis with Age in Men. Circulation 1:645 (Apr.) 1950.

Yater, W. M., Traum, A. H., et al.: Coronary Artery Disease in Men Eighteen to Thirty-nine Years of Age. Am. Heart J. 36:334 (Sept.) 1948.

[4] Larsen.[5] Page.[2]

[5] Larsen, N. P.: Stress and the Aging Circulation. Amer. Practitioner and Digest of Treat. 6:1681 (Nov.) 1955.

[6] Wilber, C. G., and Levine, V. E.: Fat Metabolism in Alaskan Eskimos. Exp. Med. & Surg. 8:422 (May-Nov.) 1950.

[7] Katz, L. N., and Stamler, J.: Experimental Atherosclerosis, Springfield, Charles C. Thomas, 1953. Kesilman.[8] Page.[2]

[8] Kesilman, M.: Incidence of Essential Hypertension in White and Negro Males. Medical Record 154:16. 1941.

that cardiovascular disease appeared to be extremely rare among our Eskimo patients, but that the occurrence of roentgenological evidence of arteriosclerosis in these Eskimos was neither more nor less than one would expect to find in Whites of similar age groups.[9]

The mean daily fat intake, which was practically all animal fat, represented about 37 to 40 per cent of the calories in the Eskimo diet, as against 38 per cent in the case of normal white men living in Alaska. The mean cholesterol intake (340 mg daily) for all Eskimos studied was comparable to that of Whites on a mixed diet, while among inland Eskimos the mean figure was of the order of 4 gm cholesterol per week, which corresponds to the group of highest habitual cholesterol intakes for normal American men reported by Keys.[10]

The serum cholesterol concentration in the Eskimo (203 mg per 100 ml) was about the same as is found in normal Whites, and the serum concentration of Sf 12-20 lipoproteins was about the same as in Whites of similar age.

The blood pressure was lower in our Eskimo subjects than in white men of corresponding age. This difference was statistically significant in the case of both the systolic and the diastolic pressure.[11]

Several reports indicate racial differences in blood pressure. Kean and Hammill[12] have examined records of blood pressure measurements in different races and found that in some races there is no tendency for arterial pressure to increase with age. Hypertension is said to be rare among Orientals,[13] Australian Aborigines[14] and Negroes in Africa,[15] while there is a higher incidence of hypertension in American Negroes than in American Whites of similar age.[16] To account for the rarity of hypertension in some races and its frequency in others, Schroeder[17] has emphasized factors such as climate; racial, hereditary and endocrine differences; and the simplicity of life and the absence of nervous strain, rather than dietary factors. On the other hand, it is well established that blood pressure increases with obesity and that hypertension is a common complication of obesity.[18]

Obesity is extremely rare in male Eskimos. Our Eskimo subjects maintain their body weight on a gross intake of roughly 3100 calories, as did our white controls. The protein consumption was considerably higher (148 gm in Eskimos as against 100 gm in Whites), the fat intake slightly higher (139 gm as against 127 gm) and the carbohydrate consumption correspondingly lower (307 gm as against 380 gm in Whites). The Eskimo consumption of minerals and vitamins was considered ample with the exception of vitamin C. The salt intake is lower than in Whites, sometimes less than 0.3 gm per person per day.

The eating habits are somewhat different in the Eskimos, inasmuch as they have no fixed meal times. The amount of food available also varies greatly, but no periods of starvation or semi-starvation were encountered during our study.

Although the total estimated energy expenditure was of the same order of magnitude (close to 3000 calories) in our Eskimo and White controls, the Eskimo maintains a much higher level of physical fitness. As judged by a standard physical fitness test,[19] the ratio of physical fitness for the average Eskimo, the well-trained Arctic soldier, and the average airman was in the order of 3.5 : 2.5 : 1.

The degree of cold exposure was probably not materially different in the two groups. The amount of sleep was about the same, roughly eight hours.

On the other hand, the Eskimo appears to take life easier than most Whites: they are essentially easy going people who avoid accomplishing today what can be postponed until tomorrow. However, this does not mean that they are not subjected to considerable physical and mental stress, both in the case of the primitive tribes who are still subject to taboos, superstition and shamen, and in the case of the more civilized Eskimo who has taken up the struggle for existence in our towns in competition with the Whites in our modern way of living.

It is evident that further studies are necessary in order to settle the question of cardiovascular disease in the Eskimo and the relation between dietary fat and cholesterol, serum lipid levels and cardiovascular disease in these people.

Such studies are now in progress in our laboratory as part of a long-range program in collaboration with several research teams. This program is designed to clarify the nature and extent of cardio-

[9] Rodahl, K.: Diet and Cardiovascular Disease in the Eskimos. Trans. of the Am. College of Cardiology 4:192 (Apr.) 1955.

[10] Keys, A.: Some Preliminary Findings from the Research Program on Cardiovascular Degeneration at the Laboratory of Physiological Hygiene. Bull. Univ. Minnesota Hospital and Minnesota Med. Foundation 20:403. 1949.

[11] Rodahl, K.: Relation of Diet to Blood Pressure in the Eskimo. Trans. of the Am. College of Cardiology 4:273 (Apr.) 1955.

[12] Kean, B. H., and Hammill, J. F.: Anthropathology of Arterial Tension. Arch. Int. Med. 83:355 (Mar.) 1949.

[13] Foster, J. H.: Blood Pressure in Foreigners in China. Arch. Int. Med. 40:38 (July) 1927.

[14] Nye, L. J.: Blood Pressure in Australian Aboriginals with Consideration of Possible Aetiological Factors in Hyperpiesia and its Relation to Civilization. Med. J. of Australia 2:1000 (Dec. 4) 1937.

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Orenstein, L. L.: Hypertension in Young Negroes. War Med. 4:422 (Oct.) 1943.

Weiss, M. M., and Prusmack, J. J.: Essential Hypertension in the Negro. Am. J. Med. Sc. 195:510 (Apr.) 1938. Kesilman.[8]

[17] Schroeder, H. A.: Hypertensive Disease, Causes and Control, Philadelphia, Lea and Febiger, 1953.

[18] Mann, G. V., and Stare, F. J.: Handbook of Nutrition, ed. 2, Chicago, American Medical Association, 1951.

[19] Rennie, D. W.: Personal communications, 1954.

vascular disease among the indigenous population of Alaska. It is hoped that these data, when correlated with ethnic factors, cultural traits, dietary habits, relative body obesity, physical fitness, and environmental exposure, will increase our knowledge of the etiological factors of cardiovascular aging.

This program consists of careful clinical examination of representative populations, including complete physical, x-ray, and electrocardiographic examinations. These data, which are being collected by Drs. Herbert Griswold and Charles Dotter of the University of Oregon Medical School in collaboration with Dr. Rennie of the Arctic Aeromedical Laboratory, will be supplemented by systematic dietary studies, serum cholesterol levels, assessment of environmental exposure, levels of physical fitness, and finally cultural studies by anthropologists residing in the different Eskimo villages. An autopsy program is being initiated by our laboratory, in cooperation with the Public Health Service and the Armed Forces Institute of Pathology, to establish the incidence of coronary and systemic atherosclerosis among the native population. Finally, the effects of diet and climatic conditions upon the mast cell numbers, heparin concentration and lipid profile of human connective tissue, and their relation to the development of atherosclerosis, are being studied under a joint project with Dr. Robert J. Boucek of the Miami Heart Institute, using the sponge biopsy technique. So far, the clinical phase of this program includes 475 coastal Eskimos. The material is now being analyzed, while the program as a whole is still in progress.

RACE AND DIFFERENTIAL AGING

WALTER M. BORTZ, II, M.D.,* and EDWARD L. BORTZ, M.D.,† Philadelphia

Aging is retarded by a restricted caloric intake and moderate physical activity, in both animals and man. These factors appear to be more significant than race.

A RETURN visit to the Hawaiian Islands on the occasion of the Centennial Celebration of your Medical Association furnishes the opportunity to greet old friends. It also creates the chance to comment on certain aspects of a major health and medical phenomenon today, namely the lengthening life span.



DR. W. BORTZ

Here in this glorious garden spot there is a fascinating interplay of different races. For the most part this is a *malihini* population; the Chinese, Japanese, Korean, Filipinos and Caucasians have found here their Shangri-La. In these Islands desegregation is no judicial wrangle. It is a way of life. This intermingling of peoples makes for a rugged social fabric.

Here we find a most exciting experiment by Nature. Under almost ideal conditions of climate there is easy and gracious living. It would be of interest and no doubt of importance, too, to search for possible pathological lesions in the different nationalities. Some light might presumably be shed on variations in life span, disease-susceptibility, and perhaps racial stamina.

Is there any apparent difference in the aging of one ethnic strain compared with another? The groups live in proximity in this pleasant setting. Any difference in diet of one group compared with another might be reflected in the pathology of blood vessels.

Taking advantage of the excellent autopsy material available from Oriental and Caucasian sources, N. P. Larsen[1] with his colleagues, Dr. Harold Civin and Walter M. Bortz, reviewed 1250 records of Queen's Hospital in 1953. In the elderly of both races, those over 65 all showed atherosclerosis. A severe type of lesion was found in younger Orientals who lived on a Caucasian type of diet, rich in animal fats and eggs. Larsen finds a real difference between the Oriental and the Caucasian clinically. Coronary artery disease was diagnosed in 3.5 per 1000 Orientals and in 16.4 Caucasians. This is explained by the fact that older Orientals tend to a diet relatively low in animal fat. As their progeny are attracted to the fat-rich diet of the Caucasians more vascular changes appear.

Dimensions of Aging

According to an old French proverb, the ability to lengthen life first is the ability not to shorten it. Aging can be accelerated or retarded in experimental animals merely by altering the caloric intake.[2] McCay shows that rats on an adequate diet but severely limited in calories will retain sleekness of coat, brightness of eyes, and a high index of fertility, to an age corresponding to 80 years in the human. The thin rats bury the fat rats, and so it is with humans according to vital statistics.

Hypertension is rare in Orientals until they participate in the questionable benefits of the high caloric Caucasian diet. So long as the Okinawans were not blessed with the benefits of civilization they showed little vascular degeneration and hypertension.[3]

Available evidence suggests that diet, emotional poise (to balance stress), exercise, exposure, heredity and climate definitely influence the functional efficiency and tissues of the circulation. An old Pennsylvania Dutch saying observes, "We grow too soon old, and too late smart."

The Diet-Exercise-Aging Axis

In a series of experiments on rabbits we found a difference in atheromatous changes in these animals forced to vigorous exercise. Four groups were studied. In 2 of these half were on a cholesterol-poor diet with no exercise; the other half were given vigorous activity. Two other groups were fed a cholesterol-rich diet, half kept at rest, the other half were exercised. Our findings showed that the groups with a low cholesterol diet plus exercise showed the least vascular deposits; those

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[1] Larsen, N. P.: Atherosclerosis—An Autopsy Study, HAWAII MED. J. 14:129 (Nov.-Dec.) 1954.

[2] Bortz, W.: Graduate thesis, Williams College, 1951.

[3] Benjamin, E. L.: Report of 200 Necropsies on Natives of Okinawa, U. S. Naval Med. Bull. 46:495 (Apr.) 1956.

with a cholesterol-rich diet and exercise likewise were less prone to cholesterol deposits in the intima than the two sedentary groups.

Much has been written about the Eskimo and his blubber diet. The rigorous climate plus vigorous physical activity may well speed up his circulation, thereby reducing the time interval for a fat-rich blood stream to bathe the vascular walls.

Exercise has until recently been an unstudied factor as it may influence atheroma deposits. Some recent reports suggest less advanced sclerosis in individuals whose occupation includes physical activity.[4] The long term effect of a moderately vigorous existence as compared to a sedentary life on the development of atherosclerotic coronary heart disease has interested physicians for many decades. Recently the effect of physical work on the development of coronary heart disease in humans has been studied from the epidemiological standpoint with some fruitful results. Morris *et al.* in an attempt to evaluate this from the Social Medicine Research Unit in England have been engaged for some time in a survey of the health records and death certificates of some 31,000 men from 35 to 64 years of age employed in the London Transport System. Conductors on trains and busses were selected to represent the active occupation group because their jobs entailed either walking or climbing, whereas the drivers of these vehicles because they sat at their work were chosen to represent the sedentary group. Notations were made of the incidence of angina, coronary occlusion, and early mortality from myocardial infarction in the two classes of workmen. Their survey showed a lower incidence of coronary artery disease as well as a lower immediate mortality from coronary artery disease in the conductor than in the driver groups.

As a further test of the incidence of coronary disease in two comparable classes of workers the medical records of over one hundred thousand male postal workers and civil servants were reviewed. Postmen who delivered mail represented the actively exercising group while supervisors, telegraph and telephone operators comprised the sedentary group. As above, the total incidence of coronary disease was significantly less in the men whose work involved exercise.

Problems of aging represent an important dimension of human existence which the medical profession has been slow in recognizing. Social workers and government at the national, state and local levels are hard pressed to satisfactorily handle our rapidly expanding older population. The tremendously important biological, emotional and social aspects of aging in which doctors would be trained have as yet found no place in the curriculums of medical schools.

The Russians claim over a million centenarians. For the United States to have such a number at the present unsatisfactory arrangement for keeping senior citizens socially useful and self supporting, would be a national calamity.

From such evidence currently known it would appear that a race which can subsist on a nutritious diet, limited in calories, that can be physically active so as to control obesity, and that can protect against excessive exhaustion, may stand the best chance of an enjoyable, useful old age.

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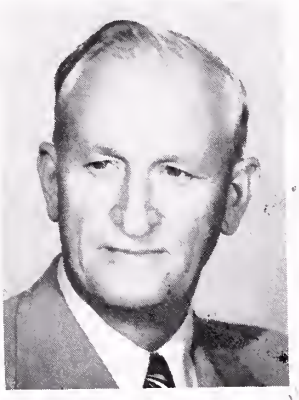
BLINDNESS IN HAWAII

A Report on All Registered Blind to December 31, 1955

FORREST J. PINKERTON, M.D., Honolulu

Hawaii's blindness rate is 1.42 per thousand as compared to a national average of 1.98. Cataract is the cause in 27%; optic atrophy, glaucoma, trauma, and systemic diseases follow in that order.

AT APPROPRIATE intervals a survey should be made of our varied programs on health, one of the most important programs being that for our "visually handicapped citizens." Such a survey must be considered of vital importance for many reasons. The following seem most important:



DR. PINKERTON

1. To become sightless is one of the most tragic calamities. Such a loss destroys in a major degree the outlook on life of any individual.
2. A second major consideration is the loss of the creative services of the blinded to their family and community. Much of this loss is intangible, and the loss of those intangible values becomes fantastically great. We must consider the "human values" above all other considerations.
3. A third major consideration of concern to every citizen is the material cost to the nation and to the locality. Our nation spends about 150 million dollars annually to care for our 320,000 blind, an average cost of $500.00 per blind individual. Added to this is the annual estimated cost to industry for compensation, medical and hospital expenses of two hundred million dollars or an estimated total of more than 350 million dollars annually.

History of Blindness in Hawaii

In early 1800 specific reference was first made to blindness among Hawaiians. In those early days history tells us of epidemics such as smallpox, which no doubt accounted for many blind individuals.

Through the years Hawaii became increasingly concerned with a program of eyesight conservation and in 1914 Gertrude A. Mason was appointed principal of the Diamond Head School for the Deaf and Blind on Oahu under the Department of Public Instruction. This was later to become a territorial boarding school, serving all counties.

In 1925 an Association for the Adult Blind was formed. Thus the community became interested in the adult problem along with that of the school children.

From 1925 interest increased in this area and many committees, agencies, councils, societies, clubs, and associations contributed to a program dedicated to the welfare of the blind, the prevention of blindness, and the conservation of eyesight. It is not possible to determine which organization did what specific work. No central organization existed which could bring all these efforts into one coordinated whole.

It was in 1935 that such a coordinating agency came into being under the name of the "Bureau of Sight Conservation and Work with the Blind" under the auspices of the Territory of Hawaii. This bureau, now twenty years of age, has not only functioned as coordinator for all the volunteer agencies interested in the blind, but has worked directly with every phase of the problem—social, educational, vocational, preventional, and direct medical care of the individual.

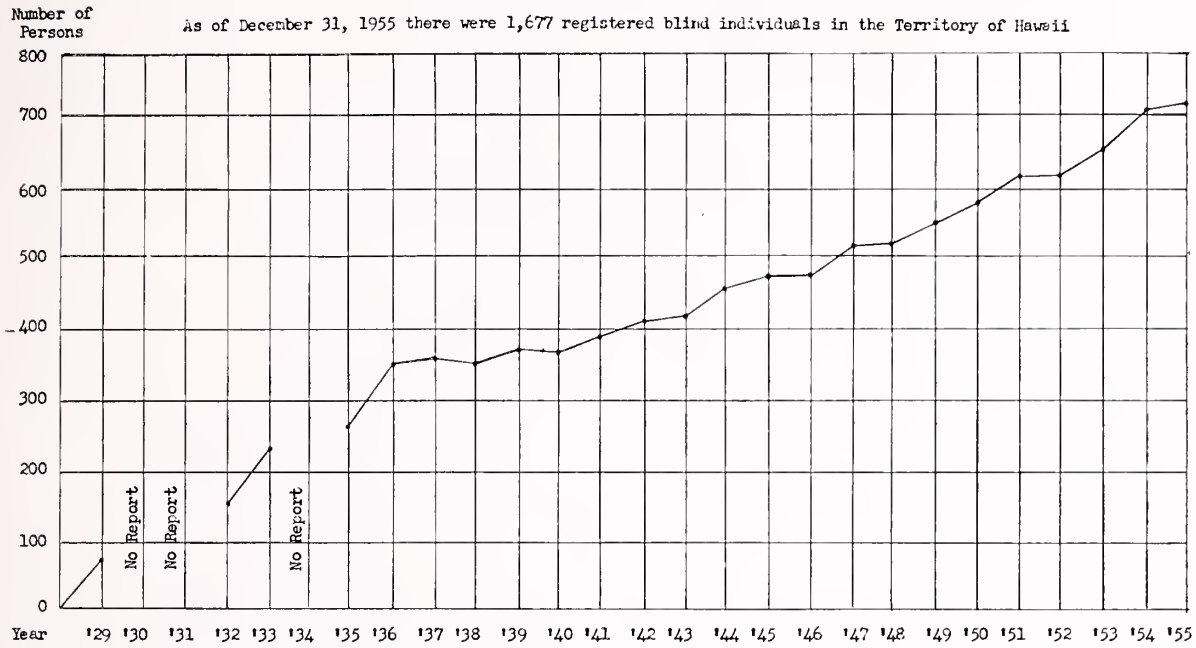
Recording Blind Cases in Hawaii

As I look back to 1917 when I first took an active interest in the health affairs of the Territory, it is apparent that we have come a long way in our progressive programs in every phase of health and welfare, including the field of Sight Conservation. In 1917 there were few individuals who could be identified as blind, yet I know there were many more blind than anyone knew about in those days, simply because there was no agency or mechanism to properly and accurately record such cases.

In 1929 we knew of only 64 blind persons on the Island of Oahu, and in October of 1932 we knew of only 156 blind persons in the Territory. In 1932 a committee on Sight Conservation was appointed by the Honorable Lawrence M. Judd, Governor of the Territory. This committee, of which I was chairman, reported a total of 223 blind persons in the Territory at the end of 1933.

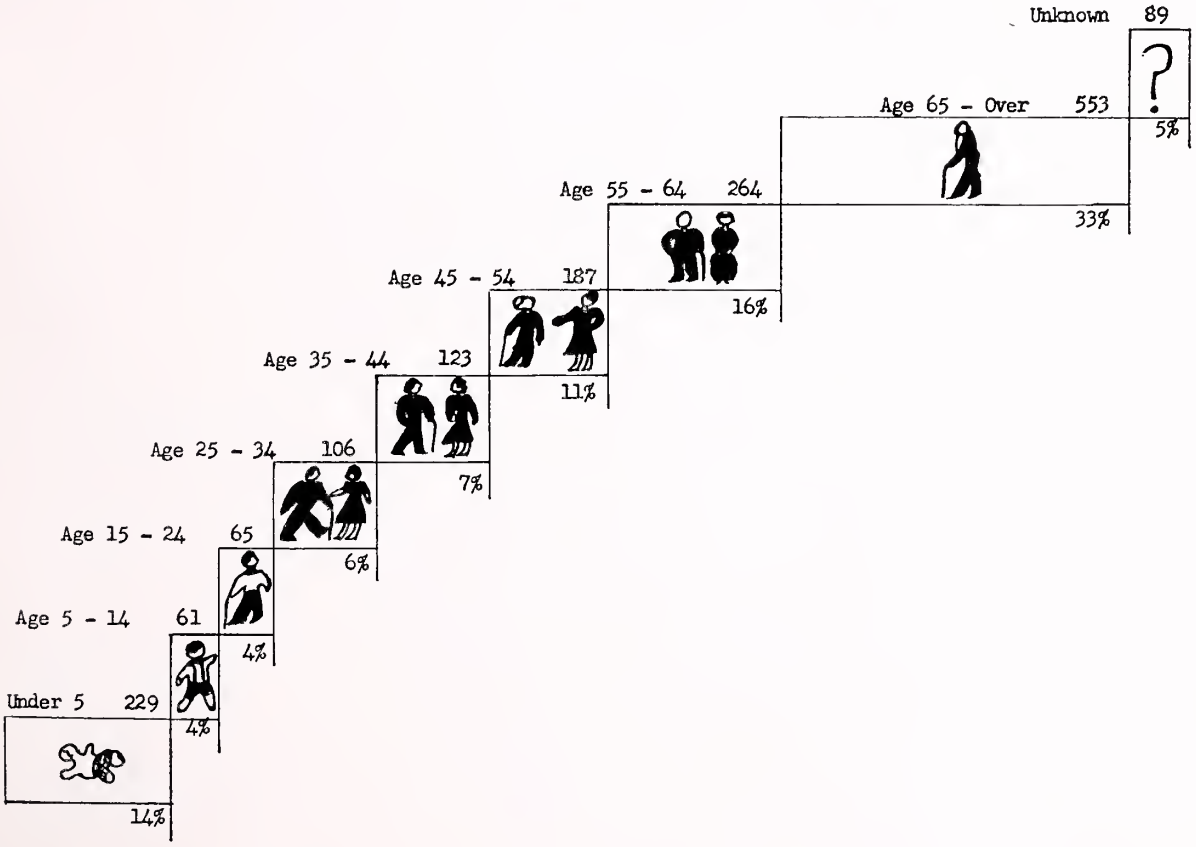
Read before the Centennial Meeting of the Hawaii Medical Association, April 27, 1956.

TABLE 1.—*Number of Persons Registered as Blind Territory of Hawaii, June 1929–December 31, 1955.*



In 1935 the Bureau of Sight Conservation and Work with the Blind was created. The Public Health Committee of the Chamber of Commerce of Honolulu, under the chairmanship of the writer, made available $2000 to the Bureau to pay for eye examinations of all known blind. Upon investigation they found that of the 266 blind persons reported by earlier committees, only

TABLE 2.—*Age at Onset of Blindness Among 1,677 Persons, Territory of Hawaii, June 29–December 31, 1955.*



178 could be certified as blind. At the end of their first year of operation, an additional 177 blind persons were certified, making a total of 355.

Under the Territorial law, the Bureau of Sight Conservation and Work with the Blind is mandated to maintain a complete register of the blind, describing the condition, causes of blindness, all pertinent data concerning the individual—age, sex, and recommendations for rehabilitation, etc. With such a mandate the Bureau, in the period from November 1, 1935 to December 31, 1955, registered 1,677 persons in the Territory of Hawaii as medically blind on the basis of ophthalmologists' reports. Because of the efforts of the Bureau, we are now able to better evaluate the causes of blindness in the Territory for the past twenty years.

Not many states have as good a system of accounting and recording of their blind populations as does Hawaii at this time. We are closely knit, and records of many of our activities are much more easily obtainable than would be the case in large states with extensive rural areas and moving populations. The majority of studies elsewhere must depend on material from the records of recipients of "welfare" and "aid to the blind."

Incidence of Blindness in the Territory

On the basis of our computed total civilian population of 500,976 as of July, 1955, and the number of living registered blind of 710 on December 31, 1955, it is estimated that our blindness rate is about 1.42 per thousand, as compared to the national average of 1.98 per thousand in 1952.

Due to intensive general, industrial and community health programs, cooperation of the ophthalmologists, newer drugs, early detection, etc., blindness is less than on the mainland. Today the picture is far better than it was two decades ago when the racial groups in this great "melting pot of races" were ruled by superstitious and religious fears which forbade modern and hygienic medical care.

In 1941 a report was made on the causes of blindness in Hawaii based on the data of that time, concerning but 340 individuals. The data in this report will be at wide variance in many respects with the report of 1941. These variations may depend on the opinions of the observers, but particularly on more complete data available today, more accurate reporting, and five times more reports for study and evaluation.

The report of the Bureau of Sight Conservation

TABLE 3.—*Blindness Among 1,677 Persons by Racial Group, Territory of Hawaii, June 1929–December 31, 1955.*

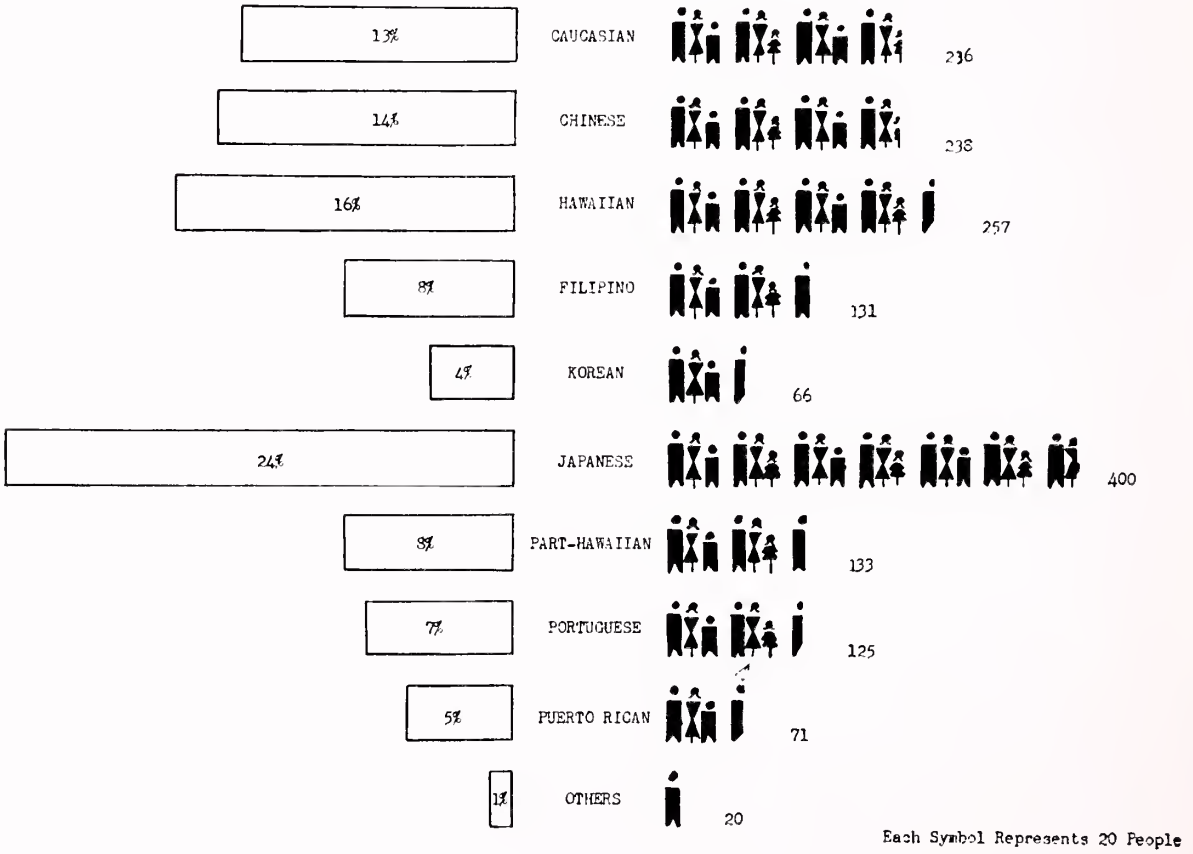
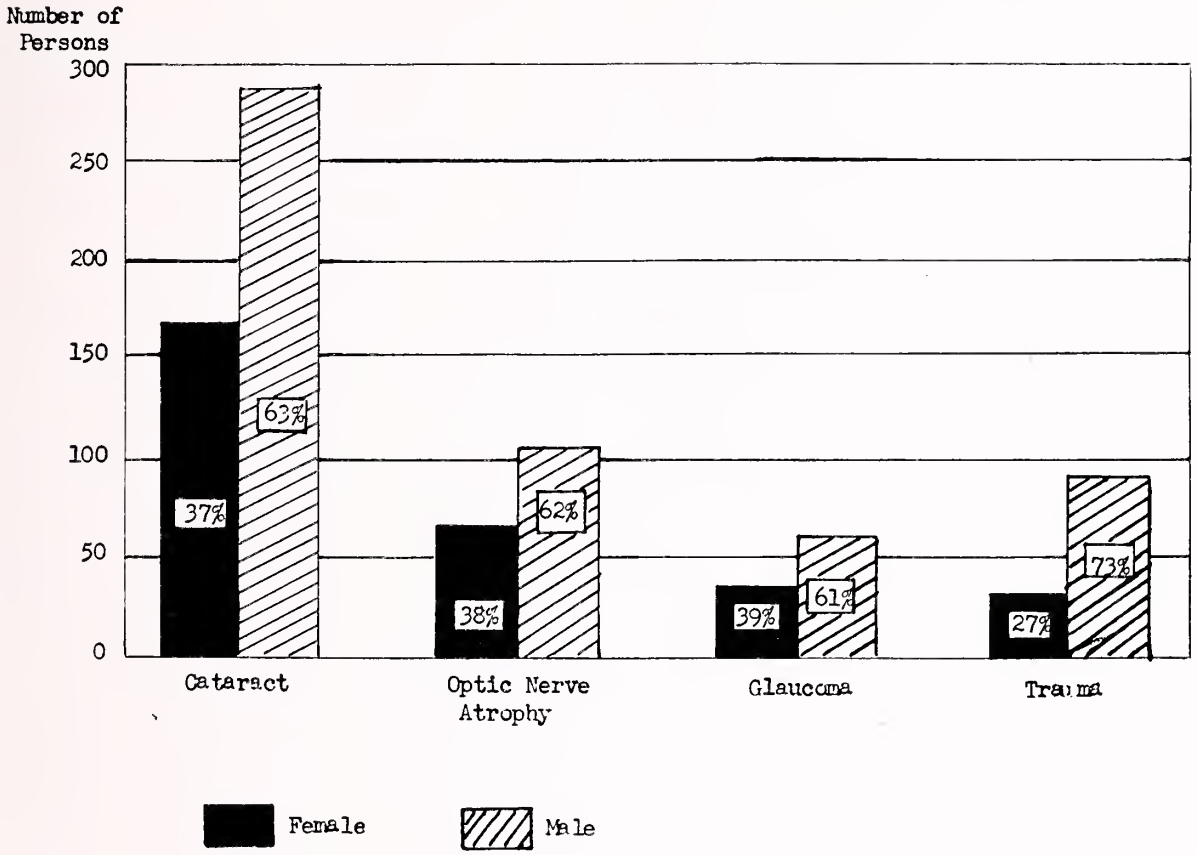


TABLE 4.—*Major Causes of Blindness Among 1,677 Persons by Site and Type of Affection, Territory of Hawaii, June 1929–December 31, 1955.*



and Work with the Blind which has registered 1,677 persons in the Territory of Hawaii shows that 1,371 of these are fully described by medical reports, while 306 had no ophthalmologist's report. This report will attempt to classify these persons as to age, sex, nationality and causes of blindness.

I know of no area in the United States where so many different races reside in such numbers as to permit reliable studies of racial characteristics regarding medical problems. There are eight dominant races or nationalities in Hawaii and it is of interest to classify the distribution of eye conditions as they affect the eye in these various racial groups. However, our estimated census of July, 1955, could not break down the classifications into a true figure. Of the 10,600 Hawaiians and 84,000 part Hawaiians, it is doubtful if this large segment of the population (18.8%) were of predominantly Hawaiian blood. Many of the 32,375 listed as Chinese during the 1955 census (totaling 6.44% of the whole population) are really varied mixtures and probably not pure Chinese at all. The census is more reliable in its classification of Japanese as pure Japanese, since they have not intermarried as frequently as other races with the exception of the Caucasian group who also intermarry less frequently. Numerically there are 185,000 Japanese in the Territory, 36.9% of the total population.

Causes of Blindness—Cataract

As we study the charts, we note at once that cataract leads by a wide margin as the cause of blindness in the Territory: 454 or 27% of our patients were blind because of cataracts.

To classify cataract in this manner is perhaps misleading because blindness is usually so classified after all curative measures have been instituted. However, in my position as "supervising ophthalmologist" for the Territory, I have been compelled to certify several cataract patients as "blind" because they refused to permit surgery, even though a careful examination rated them as good surgical risks with excellent promise of such usable vision as to remove them from the legal classification of blindness. However, refusal to permit surgery forces us to classify them as blind.

While no detailed studies were recorded denoting the exact type of cataract, it was found from the age classification that 25 of the 454 (5.50%) were in the age group up to 4 years, indicating a congenital influence. In the age group from 55 to 80 and over, 358 or 78.8% almost certainly pointed to senescence and its associated senile changes as the cause.

Of these 454 patients blind because of cataracts, 63% were male and 37% were female. In early days, males greatly predominated.

In this group it is to be noted that there were 88 classified as Hawaiian but it is doubtful if all 88 were pure Hawaiian or even predominantly of Hawaiian blood. Eighty-six were classified as Chinese, again probably of varied mixtures. Although the Japanese make up 36.9% of the total population in the Territory, only 89 or 20% were blind due to cataracts; this must mean that as a race these people are by heredity less vulnerable to cataract, or their economics and nutrition better than others, or associated causative factors are absent, or more attention to personal hygiene is practiced, or they are more cooperative and agreeable to surgery.

Other Causes of Blindness

The second highest cause of blindness in the Territory was optic nerve atrophy, which occurred in 171 cases, 106 (62%) in males, and 65 (38%) in females. These cases were fairly equally distributed over the various races in proportion to their number in the Territory, and the age groups did not suggest anything of significance.

The third largest condition causing blindness was glaucoma which was ascribed as a cause in 103 cases, about 6% of our total blind population. Of these, 62 (or 60%) were males and 41 (40%) were females. In this the Japanese predominated with 30 cases (30%), the white with 21 cases (19%) and the Chinese with 18 cases (17%). In the three nationalities the largest age group was from 50 to 54 years with 12 blind, and in the 70 to 74 age group, 16 blind. Whether glaucoma in our series was

TABLE 5.—*Major Causes of Blindness Among 1,677 Persons by Etiology, Territory of Hawaii, June 1929–December 31, 1955.*

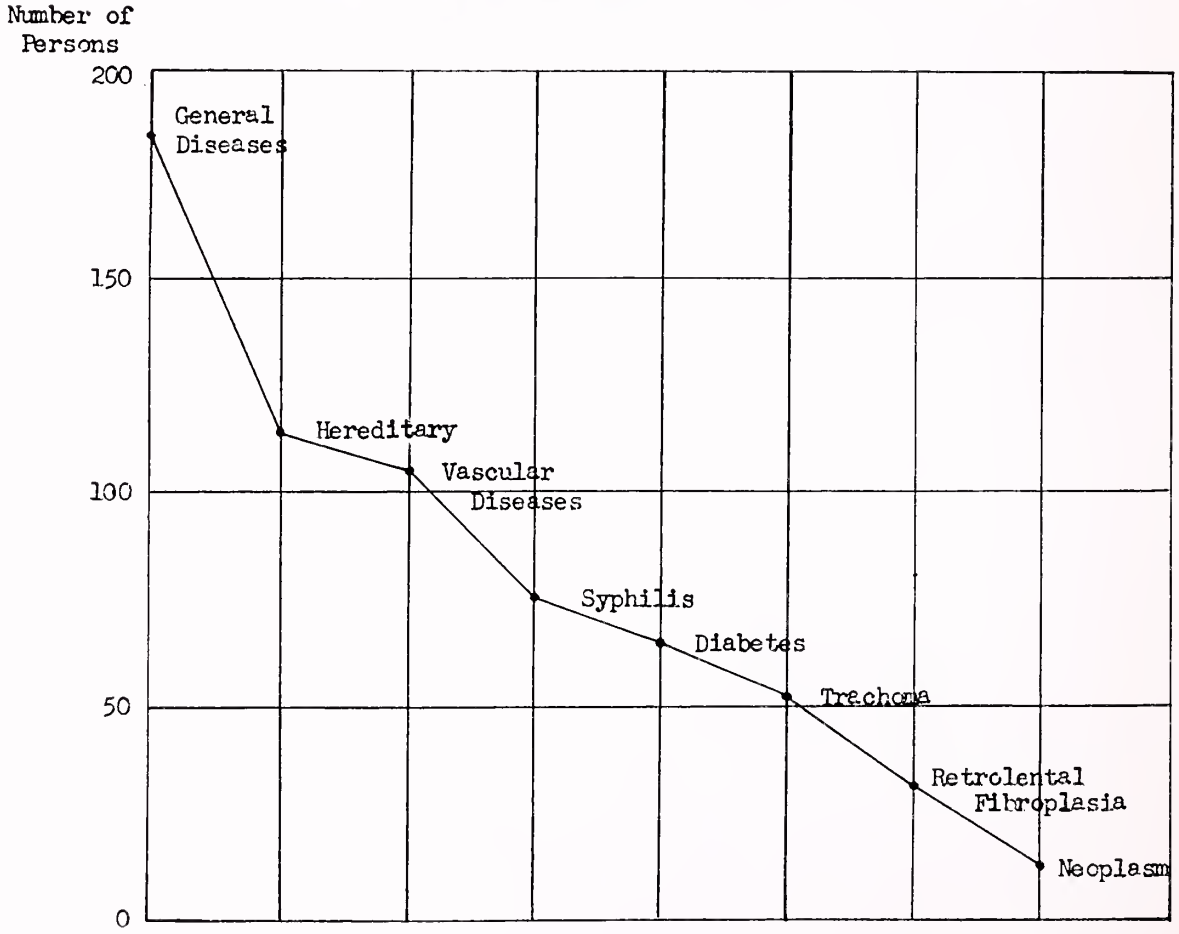
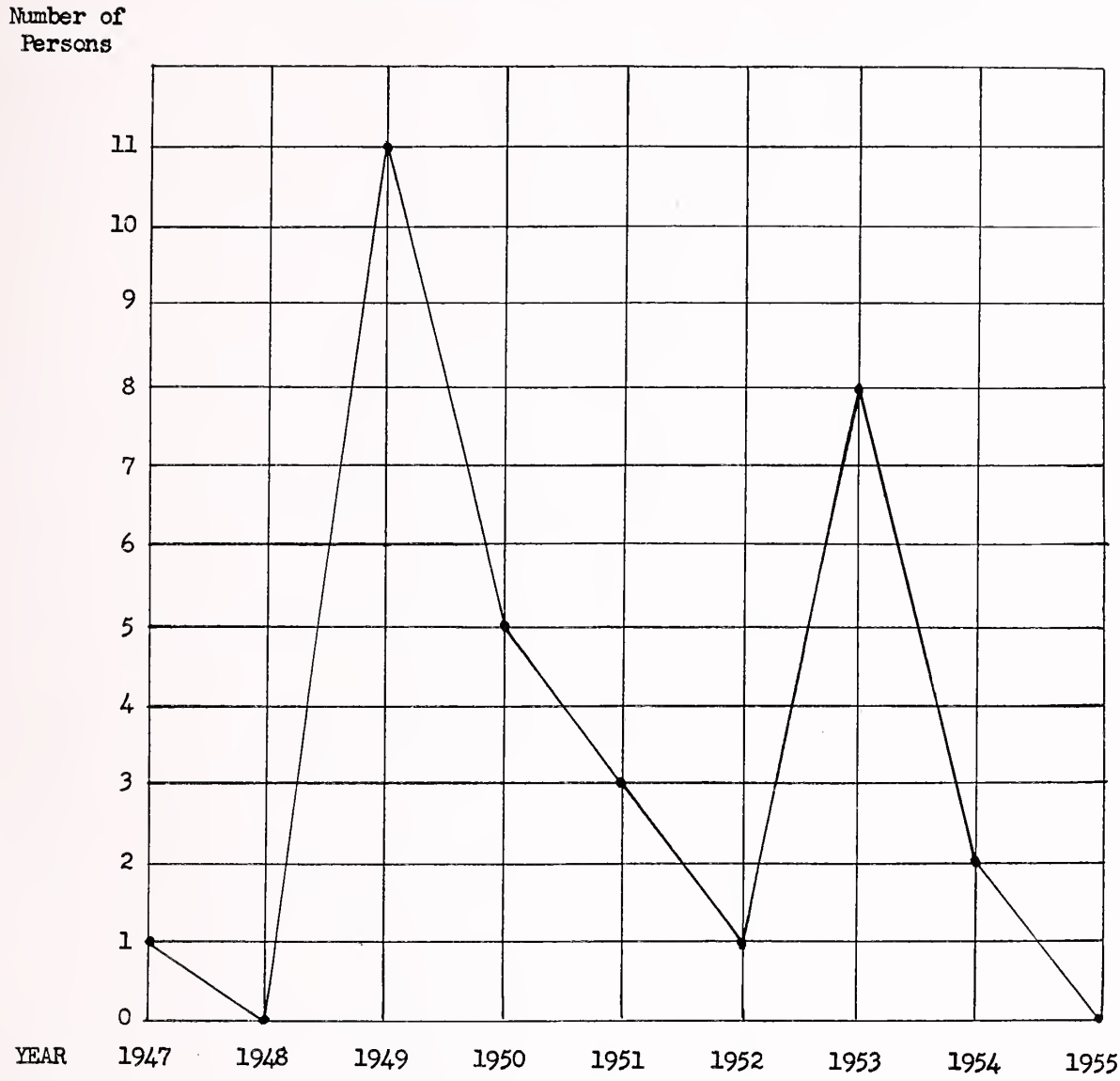


TABLE 6.—*Number of Registered Retrolental Fibroplasia.*



primary or secondary to surgery was not recorded. It was highest during World Wars II and III.

Traumatic causes of blindness occupy a high place in our case records. Consolidating such cases into one large group of accidents, occupational and non-occupational, birth processes, sports and household activities, we find approximately 124 or 7.39% of our blind due to the above grouping—90 in males and 34 in females. A logical reason for the preponderance of males over females lies in the greater industrial and other hazards to which the male is more often exposed. This is borne out from our case records since in practically every category of activities, industrial, non-industrial, sports, occupational, etc., more men were involved.

Specific Diseases

Of specific diseases as a cause of blindness, vascular diseases lead the list with 105 cases (6.3%). Here the Caucasian group of approximately 100,000 lead with 28 cases or 27%—while the Japanese group of approximately 186,000 was a close second with 27 cases or 26% of the total number of vascular diseases. In this group the Filipino, in spite of their minority population percentage, of 63,000 (9.7%) had 10 cases. A breakdown in the age groups indicates fair distribution up to age 60 after which there is a sharp increase.

The second highest etiology of blindness was due to syphilis in all forms which comprised 76 cases or 4.53% of the total blind. Our rate of

blindness due to lues is considerably below the national average. Of this 4.53%, 64 (or 84.2%) were presumably due to syphilis acquired after birth, though our records are not conclusive to make this positive. There were 42 males and 22 females; the racial division was 19 Hawaiians, 20 Japanese, 7 Filipino, 6 part Hawaiian, 5 Chinese, the remaining seven cases occurring fairly evenly in the other groups. Prenatal syphilis caused blindness in 12 (15.8%) of our cases, 8 males and 4 females, and as would be expected, seven were in the age group 0-4.

The third highest etiology of blindness was diabetes with 65 cases (3.9%), and of these, 22 (34%) were in the male and 43 (66%) in the female. In all our findings, diabetes is the only specific disease where the female was involved twice as often as the male. The Japanese had 16 cases and the Hawaiians had 15 cases. The Hawaiian is found to be frequently vulnerable to diabetes and one wonders if a connection could be established with their starch diet and general overweight. In numbers they are much less than Japanese, and starches as a contributing factor must be considered with the Japanese because of their rice diet. Diabetes caused blindness in almost 4% of our blind as compared to less than 1½%, 15 years ago. Diabetes seems to be more prevalent today than 15 to 20 years ago.

The fourth highest specific etiology of blindness was trachoma which caused 53 cases, 40 male (75.5%) and 13 female (24.5%). Forty-three of the 53 cases were in the Japanese (22) and Chinese (21). Forty-three of those blinded were in the age group from 45 to 80. It is significant to note that 15 years ago trachoma caused 8.5% of our blindness, but of the total 1,677 blind individuals in this report, only 3.2% were due to trachoma. Since importation of Chinese and Japanese labor has been discontinued, there has been excellent control and trachoma is rapidly disappearing. During those early years, these laborers arrived in Hawaii for cane field labor with the disease already well established with lid distortions, extensive scarring and advanced pannus.

Our records show but one case blind from gonorrheal ophthalmia and only 6 cases of gonorrheal ophthalmia neonatorum and 2 other unspecified cases that might have been. Assuming the 7 cases were all due to gonorrhea, this gives us a percentage of 0.41%. Statistics of 25 years ago indicate a national average of as high as 7% of blindness due to gonorrhea. Thus do we find almost incalculable monetary and human benefits derived from the educational and treatment campaign that was waged against venereal disease for several years. This campaign was particularly successful and beneficial here in Hawaii. The joint efforts of the armed forces medical department with our civilian health authorities and our Venereal Disease Bureau (formed in 1942) waged a campaign of education, blood testing and prophylaxis that reflects favorably upon the age group of that time. Prenatal regulations passed in 1943 certainly reduced to a minimum the congenital lues and Neisserian infection of the eyes at birth, and the laws requiring pre-marital physical examination and blood testing were a great step forward in the preventive program, exposing the newlyweds to a compulsory educational experience at the very onset of their marriage.

Neoplasms of all types were present in only 11 of our cases (0.7%), which is considerably lower than reported in non-caucasian countries, but tumors causing blindness in children seem to be on the increase.

Premature survival rates are increasing and this fact alone may change our rate of blindness due to other congenital defects—other than retrolental fibroplasia, the cause of which is rapidly being solved; preventive care will reduce its incidence.

In a large group considered to be prenatal in origin, and not classified elsewhere in our records, we find 75 cases of definitely established prenatal origin, and 23 cases of presumed prenatal origin. in 20 others no specific cause was stated but they were considered of prenatal origin. Thus 118 (7%) of our 1,677 cases were considered of hereditary origin, either established or presumed, 64 of whom were males and 54 females. The Japanese led the list with 45, Portuguese with 13, Filipino with 12, and the Chinese with 12.

In the broad classification of general diseases, exclusive of vascular diseases and diabetes, are included the anemias, nephritis, central nervous system disease, pregnancy, nutritional deficiencies and other general diseases not classified and unspecified, there were 184 cases of blindness or 10.97% of the total, affecting 110 males and 74 females.

It has been our experience over the years to find reports often lacking in essential data, incomplete and carelessly filled out, and without details so easily obtainable at the time the reports were originally compiled, so we have classified them as: 224 unknown to science, 102 undetermined by physician, 206 not specified, and all of them of undetermined etiology, a total of 532, which is 31.72% of the total, with 349 (65.6%) males and 183 (34.4%) females. In addition there are 306 cases without completed reports other than a name, race and age. In this group are 76 Caucasians, 55 Chinese, 52 Hawaiians, 53 Japanese, and 70 miscellaneous.

TABLE 7.—*Sex, Race and Age of Hansen's Disease in Hawaii with Number of Blind, Their Sex, Race and Ages.*

GRAND TOTAL	SEX		RACE								AGE					
	MALE	FEMALE	Hawaiian	Part Hawaiian	Caucasian	Chinese	Filipino	Japanese	Korean	Others	20–29	30–39	40–49	50–59	60–69	70–over
	62%	38%														
233	139	84	53	74	27	7	28	28	3	3	41	59	54	43	15	11
No. of Blind																
34*	21*	13*	15	8	6	0	3	2	0	0	0	4	7	13	3	7

* 15+% * 62% * 38%

In this group listed immediately above, the advanced age group was probably listed as blind with very meager data many years ago when case-reporting was less accurately and carefully done. Our increased aging population will certainly reflect in the near future an increase in glaucoma, cataract, and vascular disease.

Hansen's Disease

Hansen's disease has been endemic in Hawaii since the days of our first importation of labor to Hawaii, approximately 1850, although the exact time is not definitely known, but was probably introduced by the Chinese. In 1900 there were more than 1000 known cases of leprosy.

In the 1920's when I first began to study leprous eye diseases, there were nearly 800 Hansen's disease patients in Kalaupapa and Kalihi Receiving Stations, plus unknown numbers of undetected known at large leprous patients in the community. Hundreds of these patients were blind in one or both eyes.

Hansen's disease never involves one eye alone—though one eye may be involved first, it is but a matter of a few weeks or months before the other eye becomes affected as well.

It will be noted from the above chart that the ratio of males (62%) to females (38%) afflicted with Hansen's disease, is in exactly the same as in other diseases, but differs from the age incidence of blindness in general—being higher in the group from 30 to 39. The greatest incidence in leprosy is in the age group between 50 to 59.

While there may be other causes for blindness in the 34 leprous patients, the most logical and apparent cause was Hansen's disease, and we have listed them as such.

The most common causes of blindness are classified as to the type of lesion as follows:

Leprous irido-cyclitis	28
Leprous pannus and corneal lepromata	2
Phthisis bulbi, leprous	2
Anophthalmos—by enucleation	2

Conclusion

Of 1,677 reported blind individuals in Hawaii since 1935, 65% were males and 35% were females, with the exception of diabetes, where the incidence was reversed with 34% males and 66% females. No conclusive reasons are offered other than the greater exposure to conditions of life and employment—plus the greater incidence of vascular diseases in the male.

At one time early in our history, over the past 25 to 30 years the incidence of blindness in leprosy was far greater than it is today. It may likewise be said that trachoma 25 to 30 years ago was a far greater cause of blindness than today.

It seems impossible of proof that our various individual races are prone to any one disease that directly or indirectly caused a preponderance of blindness, especially in the past 20 years, except the tensions of life of the Caucasian.

Diet and climate must be considered as beneficial to our people, as nothing has been found to disprove this contention.

Acknowledgments

This report would have been impossible without the kind assistance and endless hours of investigation and study of my secretary, Miss Kathryn Moeller, and Mrs. Sue Lau Mattson and associates of the staff of the Bureau. Mrs. Mattson was of major assistance in the preparation of the charts and other data to complete this report.

Mrs. Grace Hamman, Director of the Bureau, has contributed greatly of her advice and assistance. Now that she has resigned from her strenuous position as head of the Bureau, her excellent services, her great energy and tireless efforts will be missed by all. It can truly be said, "Mrs. Hamman is a priceless friend of the blind. She has been a valued servant of the Territory of Hawaii and its people. Her contribution to the good of all Hawaii and the blind of other countries can not be measured by any methods known to us."

Young Hotel Building.

PSYCHOSIS AND RACE IN HAWAII

ROBERT C. SCHMITT, Honolulu

Do Japanese have more than their share of schizophrenia? Is income inversely proportional to the likelihood of mental illness? The author thinks we need more precise data to be sure of these conclusions.

THIS STUDY presents statistics on first admissions to Territorial Hospital, by racial stock, for persons with psychotic disorders. All data refer to the twelve-month period ended June 30, 1950.



MR. SCHMITT

Only recently has it become possible to compute meaningful hospitalization rates for Hawaii's various racial groups. Decennial U. S. Bureau of the Census enumerations made before 1950 routinely grouped military with civilian residents of the Territory, thereby seriously distorting the base totals needed for computation of rates. An effort was made by the Territorial Department of Health to estimate civilian population by race during the intercensal decade, but these estimates were found to be open to considerable error and were eventually abandoned. It was not until publication of the 1950 U. S. Census reports that accurate data for race cross-tabulated by age, sex and military status became available to Hawaii.[1]

Procedure

Seven racial (or ethnic) categories are recognized by the Bureau of the Census. The smallest of these groups, the "pure" or unmixed Hawaiian, is frequently combined with the part Hawaiian in Census reports and popular usage, but apparent differences in their psychiatric characteristics made it seem worthwhile to compute separate rates. (Age and sex were reported separately for "pure" Hawaiians and part Hawaiians in the Census volumes, but it was necessary to estimate military status from age-sex-specific rates for the combined group.) The part Hawaiians, in local usage, are persons with varying fractions of non-Hawaiian ancestry. The remaining ethnic groups include Caucasians, Chinese, Filipinos, and Japanese. An "all other" category consists of Puerto Ricans, Koreans, Negroes, and other miscellaneous races.

Admissions rates were based on the civilian population fifteen years of age and older. Younger persons were excluded from the computation because of their infrequent commitment to Territorial Hospital. Military personnel were excluded from base population totals for the same reason.

Limitations of sample size made calculation of separate rates for each type of mental disorder infeasible. Accordingly, it was decided to confine the analysis to "all psychoses" and the largest single grouping of psychotics, persons admitted for schizophrenia. First admissions for other reasons were too few and heterogeneous to permit computation of meaningful rates.

Patients admitted for the first time during the twelve-month period ended June 30, 1950 were included in the study. Rates were based on population totals for April 1, 1950. Data on admissions were taken from the Territorial Hospital annual report.[2]

Exclusion of data for persons admitted to other institutions in Hawaii was not thought to bias the sample unduly. Territorial Hospital is the only institution in the Islands devoted exclusively to the treatment of mental disorders, and a large percentage of the more seriously disturbed persons in Hawaii eventually receive treatment there. A small Mental Health Unit is maintained at the Queen's Hospital, but is not intended for long-term hospitalization. A similar installation at Tripler Hospital chiefly serves military personnel. Data for Territorial Hospital would thus appear

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From the Honolulu Redevelopment Agency, City and County of Honolulu.

[1] U. S. Census of Population: 1950, Detailed Characteristics, Hawaii, tables 29, 30, and 45, pages 35, 38, and 86. The inaccuracy of the Department of Health estimates has seriously affected the validity of at least one study of mental disorder rates: see Wedge, Bryant, and Abe, Shizu: Racial Incidence of Mental Disease in Hawaii. HAWAII MEDICAL JOURNAL 8:337-338 (May-June) 1949. The Wedge and Abe study was based on data for 823 patients admitted to The Queen's Hospital Psychiatric Division during 1947, and used the then-current Department of Health estimates, since largely discredited, for computation of rates.

[2] Annual Report, Department of Institutions, Territory of Hawaii, for the Year Ended June 30, 1950, table III, pp. 29-30.

to include the great majority of civilian residents admitted to treatment for major psychotic disorders.

Rates were evaluated by chi square (χ^2) analysis. This technique takes rate differences and size of sample into account in determining whether observed differences are statistically significant. Its use may be illustrated in reference to male schizophrenia rates. For all males, the rate was 0.42 per 1,000; for Chinese men, based on a population of only 12,085, it was 0.17; and for Caucasian males, with a base population of 32,252, it was 0.19. Despite the similarity of Caucasian and Chinese rates, chi square values, for reasons of sample size, differed greatly: between the Caucasian rate and the rate for men of all races, chi square was 5.13, but, between the Chinese rate and all-race rate, it was only 2.03. With one degree of freedom, chi square is statistically significant at the five percent level when equal to 3.841 or more.[3] It was therefore necessary to reject the Chinese rate as not significantly different from the rate for all races, while simultaneously accepting the significance of the rate for Caucasians.

[3] Croxton, F. E., and Cowden, D. J.: Applied General Statistics. New York: Prentice-Hall, Inc., 1940, Appendix I, p. 882.

This criterion was used in analyzing the rates for each racial group. Findings are given in the accompanying table, and summarized below.

All Psychoses

There were 0.99 first admissions per 1,000 civilians fifteen and over for all psychotic disorders during the twelve-month period studied. The rate ranged from 0.66 for Chinese to 1.85 for Hawaiians and 2.22 for "all others" (Koreans, Puerto Ricans, and Negroes). Rates were significantly above the all-race average for Filipinos (χ^2=26.52), the "all other" category (χ^2=20.01), and Hawaiians (χ^2=7.06), and significantly below average for Japanese (χ^2=8.95), and Caucasians (χ^2=4.47).

The "all psychoses" rate for males was 1.18, and ranged from 0.83 for Chinese men to 1.82 for Filipinos and 2.48 for the combined minor races. It was significantly high for both of the latter groups (χ^2=14.58 and 10.19 respectively), and significantly low for Japanese males (χ^2=8.65).

Among women, the "all psychoses" rate was 0.76 for all races. The Chinese had the lowest rate, 0.47, and the Hawaiians, the highest (2.03).

TABLE 1.—*First Admissions to Territorial Hospital, by Sex and Race: July 1, 1949 to June 30, 1950.*

SEX AND RACE	CIVILIAN POPULATION 15 AND OVER, TERR. OF HAWAII, APRIL 1, 1950	FIRST ADMISSIONS		ADMISSIONS RATES[1]		CHI SQUARE[2]	
		All psychoses	*Schizophrenia*	*All psychoses*	*Schizophrenia*	*All psychoses*	*Schizophrenia*
Both sexes							
All races	320,788	317	133	0.99	0.41		
Hawaiian	9,189	17	3	1.85	0.33	7.06	0.17
Part Hawaiian	36,132	30	14	0.83	0.39	1.03	0.08
Caucasian	68,213	52	14	0.76	0.21	4.47	9.18
Chinese	22,828	15	5	0.66	0.22	2.75	2.30
Filipino	43,202	74	20	1.71	0.46	26.52	0.28
Japanese	128,615	101	68	0.79	0.53	8.95	6.77
Other races[3]	12,609	28	9	2.22	0.71	20.01	2.89
Males							
All races	171,469	203	72	1.18	0.42		
Hawaiian	4,749	8	1	1.68	0.21	1.06	0.51
Part Hawaiian	17,041	17	7	1.00	0.41	0.56	0.01
Caucasian	32,252	33	6	1.02	0.19	0.87	5.13
Chinese	12,085	10	2	0.83	0.17	1.39	2.03
Filipino	34,032	62	16	1.82	0.47	14.58	0.25
Japanese	64,457	56	37	0.87	0.57	8.65	5.80
Other races[3]	6,853	17	3	2.48	0.44	10.19	0.01
Females							
All races	149,319	114	61	0.76	0.41		
Hawaiian	4,440	9	2	2.03	0.45	9.51	0.02
Part Hawaiian	19,091	13	7	0.68	0.37	0.20	0.09
Caucasian	35,961	19	8	0.53	0.22	3.46	4.02
Chinese	10,743	5	3	0.47	0.28	1.35	0.48
Filipino	9,170	12	4	1.31	0.44	3.81	0.03
Japanese	64,158	45	31	0.70	0.48	0.57	1.54
Other races[3]	5,756	11	6	1.91	1.04	10.30	5.62

[1] First admissions to Territorial Hospital, July 1, 1949–June 30, 1950, per 1,000 civilian population 15 and over, April 1, 1950.
[2] Between specified race and sex and all other races for same sex. A chi square value over 3.841 indicates a difference in rates that is statistically significant at the five percent level; over 6.635, at the one percent level.
[3] Chiefly Puerto Rican, Korean, and Negro (in that order).
Source: U. S. Census of Population: 1950, Detailed Characteristics Hawaii, tables 29, 30, and 45, pp. 35, 38, and 86; Annual Report, Department of Institutions, Territory of Hawaii, for the Year Ended June 30, 1950, table III, pp. 29-30.

None of the race-specific rates for females was significantly below average at the five percent level, but two were significantly above average: that for the minor races (χ^2=10.30) and the rate for Hawaiians (χ^2=9.51).

Schizophrenia

When data were limited to first admissions for schizophrenia, the all-race rate for both sexes was found to be 0.41. Both the Caucasians (with 0.21) and Chinese (0.22) had relatively low rates. At the other end of the scale were the Japanese (0.53) and "all others" (0.71). Rates were significantly below average for the Caucasians (χ^2=9.18) and above average for the Japanese (χ^2=6.77).

The male schizophrenia rate for all races was 0.42. Three racial groups had rates well below the Territorial average: the Chinese (0.17), Caucasians (0.19), and Hawaiians (0.21). The highest male rate was that found for the Japanese (0.57). Only the Caucasian rate, however, was significantly below average (χ^2=5.13). For Japanese men, chi square was 5.80.

For females of all races, the schizophrenia first admissions rate was 0.41. The lowest rate, and the only one to be significantly below average (χ^2=4.02) was that for the Caucasians (0.22). The highest rate, and the only one significantly above the Territorial average (χ^2=5.62) was that for the combined smaller races (1.04).

Summary

The foregoing analysis may be summarized as follows:

1) Caucasians and Chinese tended to have consistently low first admissions rates. Chi square analysis indicated these rates to be significantly below average for the Caucasians, but inconclusively so in the case of the Chinese.

2) Part Hawaiians were found to have rates lying very close to the all-race average. This was true for men as well as women, and for schizophrenia as well as the "all psychoses" rate.

3) "Pure" Hawaiians, especially women, had high "all psychoses" rates but near-average rates for schizophrenia.

4) The Japanese, in contrast, had relatively low "all psychoses" rates but high rates for schizophrenia.

5) The highest first admissions rates were recorded for Filipinos and the grouping of Koreans, Puerto Ricans, Negroes, and other miscellaneous ethnic stocks. Like the Hawaiians, however, the Filipinos and "other races" tended to score closer to the all-race average in schizophrenia than in total first admissions for psychosis.

Discussion

The foregoing rates obviously need further refinement. The computation of rates standardized for age, for example, would do much to remove the distortion caused by the contrasting age structures found in Hawaii's ethnic groups. Adjustments should be made as well for various other demographic factors, such as nativity, marital status, and, perhaps, educational attainment. An effort should likewise be made to isolate the racial components of the "all other races" category.

These refinements, however, are not likely to answer an even more important question: how closely do first admissions rates to mental hospitals parallel the onset of mental illness in the general population? It may be significant, for example, that hospitalization rates for mental disorders are inversely proportional to income levels reported by the U. S. Census.[4] This relationship suggests that the more affluent groups—chiefly Chinese and Caucasian—find early treatment under private practitioners, and thus seldom reach a Territorial institution. The effect of cultural attitudes toward psychiatric treatment is even more imponderable.

Despite such limitations, the present study may have value in indicating the need for future research. Even without the refinements suggested above, local psychiatrists could probably advance meaningful hypotheses to account for the variations found among Hawaii's major ethnic groups. Such hypotheses should provide a fruitful field for further analysis.

[4] U. S. Census of Population: 1950, Detailed Characteristics, Hawaii, table 63, p. 144.

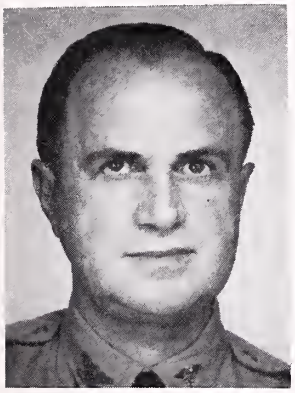
Honolulu Hale, Honolulu 13, Hawaii.

AGAMMAGLOBULINEMIA: A Working Concept

OGDEN C. BRUTON, Colonel, MC, USA,* Honolulu

The man who first described agammaglobulinemia suggests that this "experiment of nature" be classified as congenital, acquired, and secondary, and discusses clinical applications of this classification.

FOUR YEARS have passed since a new clinical entity was described and called agammaglobulinemia.[1] Let us review briefly this first case and then discuss some of the more recent developments in this "provocative experiment of nature."



COL. BRUTON

Congenital Agammaglobulinemia

A four year old boy was seen in 1946 with a clinical picture resembling osteomyelitis of the femur. His laboratory findings were consistent with that diagnosis, although serial x-rays never revealed evidence of bone pathology. His response to penicillin was prompt and complete. His past and developmental histories were considered quite normal and he had had rubeola, varicella and pneumonia without undue difficulty. The family history was also unremarkable, with one normal female sibling.

Two weeks following discharge from the hospital, he again developed a severe febrile disease; this series of events happened repeatedly and was little affected by any prophylactic measure used. Although he frequently had otitis media and pneumonia, the picture was often one of sepsis. He had clinical sepsis at least 19 times and some type of pneumococcus was recovered by blood culture on 10 different occasions in a period of four years.

Investigative procedures demonstrated that he did not produce antibodies for pneumococcus, diphtheria, or typhoid when given specific antigens. Extensive study of every body system from both a clinical and laboratory approach revealed no deviation from normal until a Tiselius electrophoretic analysis revealed the absence of serum gamma globulin. Since gamma globulin and antibody have long been thought to be related, it was immediately reasonable to think this boy might benefit from the administration of gamma globulin. He has now received, intramuscularly, 20 cc. of immune human serum globulin, containing 3.2 gms. of gamma globulin, once a month for the past 5½ years. He has remained free of serious infections during this time; however, he has suffered the usual infections of other members of his family, but not to more than the same degree. This amount of gamma globulin does not raise his measurable serum gamma globulin to a normal level, yet the protection afforded appears complete and lasts for a time period consistent with the normal human degradation of gamma globulin. This disturbance of antibody formation is not confined to the few organisms already mentioned; therefore, the infecting organisms may be varied, and the end pathology may involve any body system.

Antibody against specific blood type does not develop in these patients, and this fact has furnished the most readily available screening test for the condition;[2] the presence of measurable isohemagglutinin rules out the possibility, and those cases with no isohemagglutinin may be further confirmed by methods of serum protein fractionation.

The first several cases observed occurred in boys only, and for that reason it was felt that agammaglobulinemia represented a sex-linked recessive hereditary defect in protein synthesis, analogous to hemophilia. This is congenital agammaglobulinemia.

Other Types

The whole concept of agammaglobulinemia has become much more complex with our increasing experience with the condition, and the picture today is not as clear cut as one would believe from the preceding described congenital disease. In a

Read at the Regional Meeting of the American College of Physicians, Honolulu, March 6, 1956.

* Pediatric Service, Tripler Army Hospital.

[1] Bruton, O. C.: Agammaglobulinemia, Pediatrics 9:722 (June) 1952.

relatively short time there have been many studies reported with an ever broadening inclusion of clinical pictures into the original clear cut entity. In order to have a working concept when patients are found with low or absent gamma globulin, the following classification is offered:

I. Congenital
 a. Child
 b. Adult

II. Acquired
 a. Child
 b. Adult

III. Secondary
 a. Physiological
 b. Other diseases

Type Ia we have discussed in sufficient detail.

The existence of type Ib, or adult congenital agammaglobulinemia, is difficult to prove, and may in the future be learned to be an acquired form of the disease. Although there are forms of congenital diseases which manifest themselves only in adulthood, for example the tardive form of osteogenesis imperfecta, it would seem extremely unlikely that one could survive the hazards of many infections without the protective mechanism of specific antibody production. Nevertheless we have observed a young adult,[3] and older adults are reported,[4] who have not always had the benefit of the newer antimicrobial drugs, and who appear to fall into this group. They present the cardinal features of (1) increased susceptibility to bacterial disease, with a history sometimes dating to childhood, (2) absence of gamma globulin in the serum, (3) absence of circulating antibody in the blood and tissues and (4) failure of antibody production in response to antigenic stimulation. It further has been shown that their disorder is due to failure of synthesis of gamma globulin and is not a function of generalized protein dysmetabolism or an inordinately rapid decay of gamma globulin. For example, parenterally administered gamma globulin in these patients has essentially the same half life as for normal subjects. In addition, these patients are also benefited by routine administration of adequate amounts of gamma globulin.

Acquired Agammaglobulinemia

Type II, or acquired agammaglobulinemia, again needs further study and elucidation to give a clear understanding of its existence and mechanism. However, there is a group of cases which would seem to require an acquired explanation. This form of the disease may occur at any age and in either sex.[4] There is also the marked decrease in resistance to bacterial infection. The gamma globulin, as determined electrophoretically, is absent; however there are studies which suggest that delicate quantitative immunological methods may separate agammaglobulinemia, as diagnosed electrophoretically, into those cases with complete absence of this component and those cases with an extreme hypogammaglobulinemia.[2] Type II would appear to fall within this latter group of cases. Experimentally "immunological paralysis" has been produced in mice by use of an appropriate antigen,[5] and although the exact mechanism cannot at this time be stated, it seems entirely logical to assume that by some "influence" the human immunological system can be paralyzed so that gamma globulin and antibody can no longer be synthesized. Where failure in synthesis of gamma globulin has occurred, in type I or II, it appears to be consistent and unremitting.

Secondary Types

Type IIIa, or physiological lowering of the gamma globulin protein fraction, has been the apparent situation in many reports of cases involving infants in the first few months of life.[6] A precipitous drop in serum gamma globulin normally occurs during the first month of life.[7] This phenomenon is analogous to the physiological drop in hemoglobin during this period of life. The serum gamma globulin value rises at a time when the synthesis of gamma globulin exceeds the amount catabolized, and this transition takes place, as a rule, between 4 and 12 weeks of age. However, we have seen this physiological depression reach very low levels and remain so for several months.[8] These patients appeared to suffer increased susceptibility to infections until normal synthesis occurred and the gamma globulin level gradually rose.

It would appear extremely hazardous then, in this age group, to diagnose or prognosticate the specific protein deficiency. It would appear from the few cases observed that this group does not respond as dramatically to the administration of gamma globulin as the congenital group. Normally there is a gradual rise in gamma globulin level until the adult level is reached at about 2 years of age.

Type IIIb, low or measurably absent serum gamma globulin, is frequently observed as a mani-

[3] Janeway, C. A., Apt, L., and Gitlin, D.: Agammaglobulinemia, J. Assoc. Amer. Phys. 66:200, 1953.

[3] Christiansen, Lt. Col. C. S. Courtesy—Washington, D. C.

[4] Good, Robert A.: Agammaglobulinemia, Bull. Univ. Minn. Hosp. (Oct. 8) 1954.

[5] Felton, L. D.: Significance of Antigen in Animal Tissues, J. Immunol. 61:107 (Jan.) 1949.

[6] Fried, C. T., and Henley, W. L.: Deficiency of Gamma Globulin with Edema and Hypoproteinemia, Pediatrics 14:59 (July) 1954.

[7] Orlandini, O.: Serum Gamma Globulin in Normal Infants, Pediatrics 16:575 (Nov.) 1955.

[8] Rice, Clarence. Courtesy—Washington, D. C.

festation of many systemic diseases. This would appear to be the situation in many reports of so called "agammaglobulinemia" dealing with adults of both sexes with various disease conditions who do not demonstrate necessarily all the cardinal findings of congenital agammaglobulinemia.[4] Some of these report the presence of isohemagglutinins, or the ability to form antibody to specific antigens, or the absence of increased susceptibility to bacterial disease.

We observe this laboratory finding of low gamma globulin most frequently in pediatrics in association with nephrosis, in which the level may reach a very low figure. However, there are many other conditions in which there is disturbance of the total protein metabolism and many systemic diseases which encroach upon, or cause a dysfunction of, the reticuloendothelial system, resulting in low gamma globulin findings. It is felt these latter cases should be thought of in relation to their primary disease, and not designated agammaglobulinemia to further confuse an as yet little understood condition.

Implications

One of the most interesting sidelights growing out of the study of patients with agammaglobulinemia has been the successful homotransplantation of skin.[9] This is obviously possible in these patients only because of the absence of any immunological reactiveness. To be able to achieve this in the agammaglobulinemic subject would provoke one to speculate on the possibility that at some time in the future someone might find means of so regulating the human immunological mechanism that homotransplant of tissue may become available to all.

Speculating further, there are many unsolved problems in medicine whose nature may be clarified, and which may possibly benefited, if and when we learn to manipulate the human immunological mechanisms: The various allergies, erythroblastosis, the autoimmune hematologic disorders, rheumatic fever, lupus erythematosus, nephritis, to mention but a few of these that appear to be on the basis of a misdirected host reaction.

At this nebulous point, we can summarize by saying a classification which may be used as a working concept of agammaglobulinemia consisting of its congenital, acquired and secondary forms has been offered. The disease needs further elucidation if we are to understand clearly its ever increasing facets, and the immunological implications pertaining thereto seem boundless.

APO 438, San Francisco.

[9] Good, Robert A., and Varco, R. R.: Successful Homograft of Skin in a Child with Agammaglobulinemia, J.A.M.A. 157:713 (Feb. 26) 1955.

Case Report

CORNEAL TRANSPLANTATION

William John Holmes, M.D.
Honolulu

This is a report of the first case of successful corneal transplantation performed in the Territory of Hawaii. The patient had a corneal leukoma in his only seeing eye, the other eye being amblyopic. Following lamellar keratoplasty, his vision improved from 20/400 to 20/50.

History and Ocular Findings

F. T., age 35, a single Filipino plantation laborer, was first seen on May 18, 1955. He gave a history of receiving a foreign body in his left eye four days previously. His right vision had been poor since childhood. His past medical history was non-contributory. His physical examination and routine laboratory findings were within normal limits.

A right divergent strabismus of 30 degrees was present. The right vision was 20/300 with eccentric fixation. The vision of this eye could not be improved with glasses; however, the eye was normal in every other respect.

The left vision was reduced to an ability to count fingers at 2 feet. Photophobia, lacrimation and blepharospasm were present in the left eye. A 5 by 6 millimeter sized centrally placed ulcer was present on the left cornea. This ulcer was covered by a necrotic membrane. The left eye was also the seat of a moderately severe mixed (conjunctival and ciliary) injection. The left pupil was 2 millimeters across and irregular. The left iris appeared muddy and discolored. Details of the left ocular media could not be discerned through the necrotic membrane described above.

The diagnosis was right divergent strabismus with right amblyopia ex anopsia; left traumatic keratitis with infected corneal ulcer and iridocyclitis.

The patient was sent to the hospital. There the ulcer was cauterized with the thermophore at 152° F. for 1 minute. The pupil was dilated with 1% atropine. Both eyes were bandaged. Topical and systemic antibiotics and steroids were administered. The patient was put on high vitamin diet. On this regimen, within a month's time, the ulcer healed and the uveal inflammation had subsided. The patient left the hospital with a white left eye which had a dense central corneal scar which had reduced his left vision to 20/400. The vision of this eye could not be improved with glasses.



FIG. 1.—Eyes before surgery, showing right divergent squint and left central corneal scar.

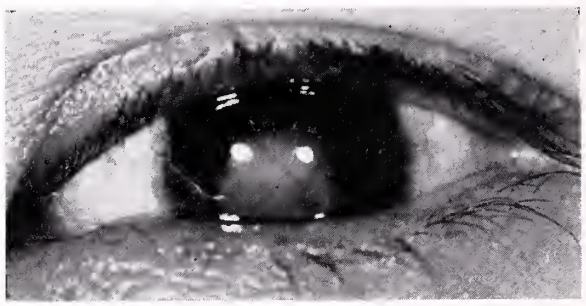


FIG. 2.—Left eye before surgery, vision 20/400.



FIG. 3.—Left eye after surgery, vision 20/50 with glasses.

Donor Eye

On May 14, 1956, at 11:00 a.m., a 56 year old Caucasian patient died of a heart attack at St. Francis Hospital. Permission was obtained from his wife to remove both eyes for the purpose of using them for corneal transplantation. Immediately following death, bacitracin ointment was instilled into the conjunctival sacs. The upper lids were pulled down over both eyes to protect the corneae from desiccation and exposure. The eyes

(*Continued on page 191*)

Received for publication October 5, 1956.



WEBSTER BOYDEN, M.D.

The President's Page

These comments might be entitled "On the Importance of Keeping Records." Records of all kinds have been kept and have proved of value even from the beginning of time—in fact, isn't that how we know time began?

The subject here, however, is medical records. To be of value these records should not be just a few words jotted on a card, as is too often found in all of our offices. They should be sufficient to substantiate and justify our diagnosis and treatment. For example, legal action for malpractice is usually not initiated until many months after the patient was last seen. Memory of the details is probably hazy for both physician and patient. Accurate, fairly complete records will strengthen the physician's position and may well be the pivotal factor in gaining a verdict favoring the physician.

It is now becoming increasingly important to record visual and hearing tests. The practice of including the visual acuity and muscle balance in pre-employment examinations is becoming more general. In addition to the immediate value, the records will be important in case of later industrial accidents involving the eyes. A record of pre-existing abnormality would prevent unfavorable legal action.

Programs for the detection of hearing defects in the schools are comparatively young, and hearing tests are probably infrequently included in pre-employment examinations. Yet such records can be important in certain cases of head injury. If the patient claims hearing loss and there is no previously recorded hearing test, an award will usually be granted even though the loss cannot be definitely proved to have resulted from the accident. Also to be borne in mind, and important to both employee and employer, is that an individual employed in a noisy environment may sustain irreversible hearing loss. In such employment situations, repeated audiometric examinations should be done, so that early impairment can be detected. This should alert the employer to institute adequate protective and precautionary measures.

W. Boyden

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[EDITORIALS]

Service vs. Indemnity

"Service" medical insurance plans, like Hawaii's H.M.S.A., provide the patient with the doctor's services, for the most part, in contrast to "indemnity" plans, which merely provide him with enough money to pay a substantial part of the doctor's bill.

It is argued by proponents of this type of plan that patients will accept nothing less than this—and labor leaders whose long-range plans envision nothing less than nationwide socialized medicine are of the same mind.

We think they're wrong. We think the American public is well educated in respect to indemnity plans through their familiarity with the cost of collision insurance for automobiles. Every car owner knows he cannot afford full coverage for this; every car owner settles for a deductible policy.

It is the view of Blue Cross and Shield, and several commercial medical insurance companies, whose representatives gathered to discuss these matters earlier this year, that prepayment plans should not attempt to cover the total cost of illness. They should, instead, merely try to insure that no person shall encounter financial hardship as a result of illness.

Coverage of the total cost deprives the young, little known, not specially trained physician of one means of inducing patients to consult him: charging them a little less than a specialist would. Such plans give an unfair advantage to the well-established, well-known physicians.

The rigidly fixed fee, which takes no account of the quality of the service or the demand for it, is an illogical, unbusinesslike device, the use of which should be sharply restricted. To the extent that low income level clauses restrict this use, we are in favor of them.

Social Security Amendments

On August 1, 1956, H.R. 7225 became Public Law 880 of the second session of the 84th Congress. Social Security was thereby extended to over half a million farmers and nearly a quarter of a million self-employed lawyers, dentists and other persons not previously covered.

By an ironic paradox, the law also provides grants for research into ways of helping people to "overcome dependency."

The original bill lowered the retirement age for all women. The new law permits employed women, and wives, to accept reduced benefits at an earlier age, or full benefits at the regular age of 65, or at 62 for widows.

Of major interest to physicians are the bitterly contested disability provisions of the new law, which are expected to apply to from about a quarter of a million (President Eisenhower's guess) to perhaps 2 or 3 million disabled persons over 50. An applicant for such payments must, among other things:

1. Prove he is "unable to engage in any substantial gainful activity." The word "substantial" is not defined.

2. Have a "medically determinable physical or mental impairment which can be expected to result in death or be of long-continued and indefinite duration."

3. Submit physician reports detailing diagnosis, history and clinical findings to establish the nature, severity and probable duration of the condition.

4. Accept any available state vocational rehabilitation services unless there is good cause for refusal.

5. Have a permanent disability at least six months before payments start.

Congress's own misgivings about these provisions of the law are reflected in the Senate's passage of them by a vote of only 47 to 45, and in their creation of separate financing for the disability provisions, lest they wreck the entire Social Security program by their potentially high cost. A 12% increase in Social Security taxes is expected (perhaps "hoped" would be a better word) to cover this cost initially. As with the whole program, however, financing is to be with borrowed money and not with the taxes supposedly levied for the purpose.

Keep your aspirin handy, doctor. This is going to be a headache!

The "Detail Man"

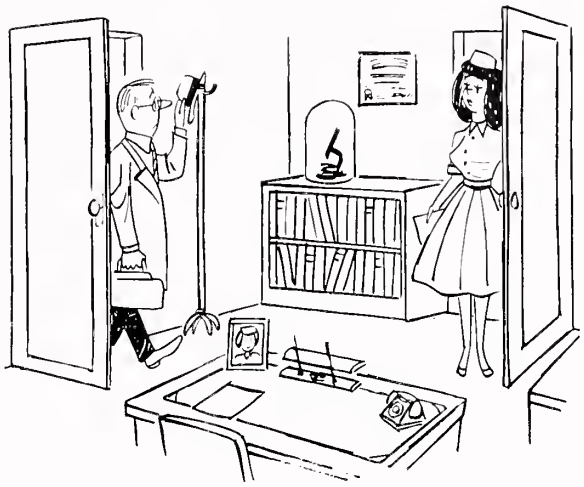
Pharmaceutical research reaches most physicians primarily through the good offices of the Professional Service Representative—better known to most American physicians as the "detail* man." The *Proceedings of the Society for Experimental Biology and Medicine,* and other magazines of that ilk, attract but few readers among the medical population, and it is to be feared that many pharmaceutical house circulars get pretty cursory scanning by most physicians on their way from the postman to the trashman.

The detail man is far more than a wholesale pill peddler. He is a professional man, who voluntarily accepts ethical restrictions on his conduct. He usually has a college degree, and often a degree in pharmacy. He has been intensively indoctrinated, so that he can impart the story of a new drug, or an improved old drug, in the shortest possible time and in the clearest possible way. He does not, like a lay salesman, insult his clients' intelligence with vague and unsupported claims about his wares. Rather, he quietly and clearly explains the advantages and—if any—the disadvantages of those wares that the physician can make up his own mind about them.

He stands ready, too, to transmit to his employers any questions or complaints regarding their products, and to discuss problems or misunderstandings regarding "pricing policy" in connection with them. Such services are especially needed in Hawaii, where a majority of doctors, both rural and urban, engage to a varying degree in dispensing medications directly to their patients.

Experienced physicians are fully aware of the value of the detail man's services and of his fund of professional knowledge about his products, and eagerly avail themselves of both, whenever he calls on them. Young physicians are sometimes a little inclined to consider his visits an intrusion on their busy office time. The sooner they get over this misunderstanding, and find time to sit down with him and hear what he has to say, the better for them. They'll find the time usefully spent.

* The accent is on the first syllable. It is the verb, not the noun, which has become an adjective here.



"Five detail men, three salesmen, two insurance representatives, and one patient to see you, Doctor."
Pfizer *Spectrum*

OASI for Physicians?

"If you can't have voluntary Social Security, will you oppose compulsory?" We said editorially in our last issue that this question had not been asked.

Now it has. *Medical Economics* asked it of some 35,000 self-employed physicians; 11,000 replied, and about half the replies were complete enough to be sorted into a balanced representation of the whole group.

The answer, as reported in their September issue,[1] was three to two against compulsory inclusion under OASI—59.8% opposed, 40.2% in favor.

A detailed analysis of the statistics brought out the interesting observation that four groups of doctors voted the other way. Favoring compulsory inclusion under OASI, by a small margin, were: those longest in practice, those earning the least, those practicing in cities of over 500,000 population, and specialists generally, including 57% of dermatologists and 64% of psychiatrists!

The poll confirms the conclusion drawn by Dr. Dickinson from the survey of state-conducted polls carried out a year ago, that a majority of American physicians are opposed to compulsory OASI coverage. It is interesting and instructive to see how a 60-40 division of opinion becomes a virtually 100-0 one when expressed by a representative body like the A.M.A.'s House of Delegates.

[1] Medical Economics 33:116 (Sept.) 1956.

Readership Poll

Our thanks to the 240 doctors and 147 nurses who took time to check off their preference, or lack of it, for the various sections of the HAWAII MEDICAL JOURNAL AND INTER-ISLAND NURSES' BULLETIN, on the post card poll distributed last fall. It has been said that statistics are like a Bikini bathing suit—what they reveal is interesting, but what they conceal is vital. We believe this—but here is what these statistics revealed, as we see it. A partial tabulation of results follows:

Seventy per cent of the doctors who replied said that they usually read the scientific articles and the editorials, and over 50 per cent usually read *This is What's New*. Adding these votes to the "I'd like more" votes, and the "I seldom read" to "I'd like less," the ratios of favorable votes for these three sections were 19:1, 15:1, and 8:1 respectively. The remaining departments ranged from In Memoriam and Medical Economics, at 3.6:1 and 3.5:1 respectively, to the Library page at 1.5:1 (though 100 doctors thought the latter "OK as is," almost the same number of votes cast for the scientific articles and editorials); only two departments, *Perhaps It's Your Nerves* and *Woman's Auxiliary*, received a negative vote, 0.8:1 and 0.1:1 respectively, with only 60 votes each for "OK as is."

The nurses' ballots are hard to interpret, partly because of the small return and partly because the poll was taken at a time when there was widespread dissatisfaction with the Inter-Island Nurses' Bulletin in principle. Nevertheless the ratio of favorable votes to negative ones was high—17:1 for the Bulletin as a whole, and for pictures in it, 15:1 for local news, 7:1 for national news, and 4:1 for the President's Message. The nurses' appetite for news was also evident in their favorable vote on *This is What's New* (17:1) and *Notes and News* (14:1 as compared to the doctors' vote of only 3:1). Nearly two-thirds of the nurses replying reported that they usually read the scientific articles, the editorials, and *This is What's New*.

We're not sure whether these figures constitute approval or not, though the "Remarks" occasionally contributed were on the whole highly complimentary. We expect to continue to be our own severest critic, and that side of our nature has been handed some ammunition, which we promise to use. We'll repeat the poll some time; meanwhile, let us hear from you any time you have something to say. We're all ears.

Join Your Chamber of Commerce!

We recently urged all physicians to join the Chamber of Commerce in their community as one means of acquitting themselves of their civic responsibilities.

The Board of Governors of the Honolulu County Medical Society at their meeting on August 23 adopted the following resolution, which is presented here in the hope that it will influence our readers:

WHEREAS, It is the duty of every physician to be a good citizen, and

WHEREAS, The responsibilities of the physician extend not only to the individual but also to society, and demand his cooperation and participation in activities which have as their objective the improvement of the health and welfare of the individual and the community, and

	I READ		I'D LIKE		TOTAL		RATIO	NURSES'
	Usually	*Seldom*	*More*	*Less*	*Pro*	*Con*	FOR	RATIO
Two Hundred Forty Doctors								
Scientific articles	160	8	29	2	190	10	19:1	2.3:1
Editorials	160	8	10	3	170	11	15:1	1.8:1
This is What's New!	131	16	33	4	164	20	8:1	17:1
In Memoriam	120	33	9	3	131	36	3.6:1	2.5:1
Bureau of Medical Economics	151	37	10	9	161	46	3.5:1	1.3:1
Notes and News	126	15	19	28	145	43	3:1	14:1
H.M.S.A.	100	33	8	6	108	39	2.7:1	2.2:1
County Society Reports	108	31	19	28	127	59	2:1	2:1
Ten Years Ago	101	36	3	12	104	48	2:1	2.6:1
Library	80	47	7	7	87	54	1.5:1	1.6:1
Perhaps It's Your Nerves	60	62	5	19	65	81	0.8:1	2.4:1
Woman's Auxiliary	12	115	3	25	15	140	0.1:1	1:1
One Hundred Forty-seven Nurses								
Inter-Island Nurses' Bulletin	53	4	31	1	84	5		17:1
Local News	88	3	30	5	118	8		15:1
National News	75	9	25	5	100	14		7:1
Pictures	49	2	35	3	84	5		17:1

WHEREAS, The Honolulu Chamber of Commerce is one of Honolulu's voluntary civic organizations whose objective is the betterment of the community, now therefore be it

Resolved, That the Board of Governors of the Honolulu County Medical Society recommends to the Society's members that they, as individuals, join the Honolulu Chamber of Commerce and participate in the Chamber's activities for the improvement of the health and welfare of the individual and the community.

This is good citizenship, and good public relations—and the medical profession is helped by both!

Disease Prevention*

It is argued as a matter of principle, by many persons both in and out of the medical profession, that the government has no business trying to prevent diseases which are not communicable. An eloquent guest editorial by Mr. James Kilpatrick in the July issue of *Northwest Medicine* views such attempts as the beginning of the end for all personal freedom, and condemns water fluoridation for the prevention of tooth decay as a program straight from the pages of George Orwell's *1984*. If tooth decay ought to be prevented, says Mr. Kilpatrick, so should pot bellies. If children can be compelled to drink fluoridated water, then editorial writers can be compelled to perform daily calisthenics.

Though we suspect the calisthenics would be good for most editorial writers, we would defend to the death, in Voltaire's phrase, their right not to perform them. We admit, moreover, the seeming logic of Mr. Kilpatrick's argument. Nevertheless, we think he's wrong about the prevention of non-contagious diseases. And this is why.

In the first place, communicable disease (which Mr. Kilpatrick evidently thinks it is all right for the government to prevent) is not essentially different from other preventable diseases. If Mr. Kilpatrick wants to be protected against smallpox, he need not insist that his neighbors be vaccinated. He need only have himself vaccinated. If he does not want to have typhoid fever, he needn't make his neighbors drink chlorinated water, or pay for a community water purification system. It will suffice if he merely chlorinates or boils water for his own personal use. These examples could be multiplied indefinitely. The point is that communicable diseases are prevented by law not because they're communicable, but because they can be prevented without harm to the people, at a cost which is less than that of permitting them to occur. Suicide has been illegal for centuries—and it isn't contagious!

In the second place, in our modern world more than in that of John Donne, "No manne is an ilande." People are all dependent upon one another. It is largely this fact that justifies, for example, compulsory education. Were Mr. Kilpatrick's view sound, it would be a crime to compel citizens to finance public schools merely to prevent a harmless thing like illiteracy—which anyone who wished could prevent on his own, at home, anyway. Compulsory education is justified on the ground—among others—that illiterate people are a financial burden on literate people. Similarly, sick people are a burden on healthy ones; a man has no right to be unnecessarily sick, any more than to be unnecessarily dead. Dental caries does contribute to disease—to oral sepsis, to malnutrition, to mouth cancer. It costs money to treat it, and it costs money to leave it untreated. It is a financial burden on the community.

In the third place, a thing is not necessarily wrong merely because it might be abused. Compulsory education is not wrong merely because the government could require children to study foolish or wicked things as well as sensible and right ones. Mr. Kilpatrick's suggestion that a government which can require him to drink fluoridated water might also require him to perform daily calisthenics is a frivolous one. This is as improbable as that the public schools might decide to require all students to learn how to dynamite bridges and railroads.

The basic fact which Mr. Kilpatrick ignores is that the human race has a long and admirable record of united, cooperative community programs to handle a multitude of problems which can be handled better jointly than they can be handled by individuals. Education, water purification, certification of pure foods and drugs—the list could be extended for pages—can be done more cheaply and effectively, for the good of all, by the community than by separate individuals. This is socialism. Maybe it is actually Socialism—but one prefers to reserve the capital S for excessive degrees of the process.

As long as we do these things for ourselves, by the "voluntary cooperation of a free people," they are good. If the time comes when they are forced down our unwilling throats by an authoritarian government, that will be the time to call a halt while we "turn the rascals out."

I want fluoridation of our city's water supply, and so do the overwhelming majority of my well-informed friends. The only opponents of this measure in my community are those who are not well informed about it, or who are confused, like

* Guest editorial by Dr. Harry L. Arnold, Jr., reprinted from *Northwest Medicine*, Sept., 1956.

Mr. Kilpatrick, by fear of totalitarianism. When a majority of thoughtful, informed citizens want to do something in a cooperative way for the betterment of their own or their children's health, they have a moral right to do it, and a moral right, within reasonable limits, to require the minority to do it too. In regard to fluoridation, courts across the nation have agreed, with almost complete unanimity, that they have a legal right to do it as well.

Mr. Kilpatrick is way out in left field—or maybe it's right field—and he had better move in a little further toward the center.

The American Physician and The World Medical Association

The World Medical Association has become a strong factor in protecting and promoting the professional interests of the medical profession and the cause of world peace.

Now in its 9th year, W.M.A. is a federation of the most representative national medical association in each of 52 nations. These member organizations represent more than 700,000 physicians. The American Medical Association is a leading member of The World Medical Association.

Doctors of medicine the world over cherish the same basic ideals of conduct and the same devotion to the welfare of mankind. The World Medical Association is cultivating the common purposes of the profession. This growing community of interest is a source of strength to the physicians in every land.

Already, by solid accomplishments, The World Medical Association has earned the right to call itself "the international voice of organized medicine." Thanks largely to the United States Committee and similar supporting committees of physicians in other leading nations, W.M.A. has a well-tried constitutional structure, a small but efficient secretariat, and a tri-lingual journal whose world-wide influence and value to the profession is rapidly growing. The permanent office of the secretariat—which serves both the Association and the United States Committee, is located in the United States.

The membership of the United States Committee has been growing slowly but steadily. In 1955, the Committee reached its first important milestone of growth: a membership of 5,000 American physicians.

The World Medical Association assists traveling physicians by providing them with introductions to colleagues in other countries, by making speaking engagements for them abroad, by acquainting them with visiting doctors from other countries, and, of course, by sending the *World Medical Journal* to members of all national supporting committees.

The activities of W.M.A. in the field of social security are of particular interest to American physicians. They have revealed boldly and unmistakably the physician's inherent and universal need for freedom from third-party interference with the practice of medicine. Such activities should not only fortify but inspire the efforts of American medicine to solve our socio-economic problems without resort to governmental subsidy or control.

On the international stage, The World Medical Association has endeavored to counter efforts of the International Social Security Association and the International Labour Organization to promote state medicine under social security programs. The World Medical Association has earned the respect of the International Labour Organization for its defense of the interests of medicine against the International Labour Organization Convention for Medical Socialization in 1952. Now The World Medical Association is attempting to wrest from the International Labour Organization the recognized world leadership in the field of occupational medicine.

For all these activities, and for many more which demand our attention, additional funds are needed. Each new member not only contributes his nominal membership dues, but, more vitally, he lends his name and influence to the program of the W.M.A. and of its United States Committee.

America's world leadership challenges America's physicians to make the United States Committee a truly impressive and representative body of American physicians.

Every individual physician in the U. S. A. is eligible for membership in the United States Committee. Annual membership dues are $10.00. The dues for Patron Members are $100.00 or more. Many of our members regularly make contributions to the U. S. Committee, in addition to their annual dues. All such contributions to the United States Committee of The World Medical Association are tax deductible.

As the international voice of organized medicine, The World Medical Association is speaking for you. It is seeking to promote and protect your interests. You are urgently invited to help these efforts along, by joining the United States Committee, and participating in its work.

Louis H. Bauer, M.D.

This is What's New!

What is the **life span of a platelet?** Previous transfusion experiments indicated that the survival time of three to six days was about it. However, these techniques have not been entirely satisfactory. Dutch workers using platelets tagged with radioactive phosphorus find a life span of about **eight to nine days.** In two patients with chronic myeloid leukemia, the life span of the platelets appeared to be normal. (*J. Clin. Invest.* [Sept.] 1956.)

With the rather short life span of platelets mentioned above, it is surprising that platelet transfusion does much good in thrombocytopenic states. However, **stored frozen platelets** were given to severely ill thrombocytopenic children, with transitory hemostasis in most of them. There was no evidence of thrombosis at the site of venipuncture or elsewhere. (*Blood* [Aug.] 1956.)

Hiatus hernia is a fairly common cause of **heartburn** in **pregnancy,** according to obstetricians at Temple University Hospital. The hernia usually appears toward the latter part of pregnancy and is more common in older multiparas. Almost 50 per cent of patients with heartburn and three or more pregnancies had hiatal hernias. The hernia usually disappears or decreases in size after delivery. Treatment: elevate the head of the bed. (*Obst. & Gynec.* [Sept.] 1956.)

A **single injection** of **Salk vaccine,** given to 4,000 Massachusetts children, gave them a fair immunity against paralytic and bulbar **poliomyelitis.** During state-wide epidemic that developed shortly after the single injection, the attack rate in the non-vaccinated children was 10 to 20 times that of the vaccinated group. (*New Eng. J. Med.* [Aug. 23] 1956.)

At the University of Illinois, the Department of Psychiatry has joined forces with the Department of Biochemistry to feed **Siamese fighting fish** tranquilizing drugs. These small creatures, which usually fight at the flare of a fin, lost all interest in fighting when subjected to the effect of **reserpine, meprobamate** or **chlorpromazine.** On the other hand, the salicylates, and morphine, made them fighting mad. Any licensed physician who has been plagued by these pugnacious specimens can obtain the dose employed by looking in *Science* (Sept. 7) 1956.

Aspirin is good for a headache but not so good for the gastric mucosa. Kelly, of New York, reports a series of patients with **gastric hemorrhage** attributable to salicylate ingestion. This was not due to the hypoprothrombinemic effect of salicylates, which parallels the total dosage. Gastric allergy to salicylates may be the cause of the hemorrhage. The incidence of this is frequent enough to justify questioning all patients with upper gastrointestinal hemorrhage as to whether they have been taking aspirin recently. (*Am. J. Med. Sci.* [Aug.] 1956.)

As further reports on the clinical use of the **anti-diabetic sulfonamides** appear, it becomes obvious that the preparations used thus far are not safe for routine use in even the mild adult diabetic. After summarizing their experiences to date in the *British Medical Journal*, these workers advise that because of a small number of cases of severe **agranulocytosis** and **thrombocytopenia** developing in Great Britain and America, these hypoglycemic sulfonamides should be used only under careful hospital supervision. The research chemists will have to shift a few bonds and radicals here and there before these preparations will be safe for any large numbers of patients. (*Brit. Med. J.* [Aug. 25] 1956.)

The virus of **lymphocytic choriomeningitis** was injected into **leukemic guinea pigs.** The infected guinea pigs survived longer than their litter mates and their spleens decreased in size after receiving the virus. And why is medical research often discouraging? **Leukemic mice** receiving the same treatment neither survived longer nor had any regression of their leukemic lesions. (*J. Nat'l. Cancer Institute* [Aug.] 1956.)

FRED I. GILBERT, JR., M.D.

Perhaps It's Your Nerves

THE PSYCHIATRIST AS A CONSULTANT

One of the most valuable aspects of specialty practice is that of acting in a consultant capacity to one's professional colleagues. This is most certainly true of the psychiatrist. This great potential contribution is only meagerly used by other doctors. Besides psychotherapy, this area of service is one of the most important that the present-day psychiatrist can offer.

The tendency is to refer a case to a psychiatrist so that he will take over the treatment responsibility. This is usually quite justified in the cases that are referred, since it takes special training and experience to carry out therapy in a serious personality disorder. But what of the more "everyday" personality problems: the mild hypochondriac, the "psychosomatic" case, the over-dependent patient, the uncooperative diabetic, the precarious cardiac case, the surgery addict? These are a few examples from every-day medical practice in which neurotic needs and tensions play a significant part in the presenting picture. No doctor denies the importance of the emotional aspects of the picture, but many are naturally uncertain as to what to do about them.

At this point, an evaluative psychiatric interview with the patient could help. Another alternative is a personal conference between psychiatrist and treating physician, either privately or at a staff conference where various angles of physical and psychological management can be discussed. This conference is often of great value to both physicians in terms of sharing experiences as well as in relation to the handling of a specific case. Even an informal phone call to a psychiatric colleague may be of definite help in getting a therapeutic "tip."

The psychiatrist can be useful during the diagnostic phase, the treatment planning phase, or at any time during the course of treatment of a patient. The custom of using him as a "last resort" after all else fails is unfair to both patient and psychiatrist, but even then, some good may be done, much to everyone's surprise!

Discussion of the case and recommendations do not need to be couched in "psychiatric jargon" anymore than the case need be discussed in surgical or pathology "jargon." Written communications between treating physician and consulting psychiatrist seem most effective when combined with a personal chat.

In 1949 the writer initiated the arrangement of having a psychiatrist as part of the medical outpatient clinic team at the New Haven Hospital in Connecticut. The patients were not aware that one of the men seeing them was a psychiatrist. This team worked to great advantage for diagnostic, treatment and teaching purposes. The program still continues. Although this is a structural arrangement illustrative of the thesis of this editorial, it is also possible for less formal arrangements to have equally significant value.

The use of the psychiatrist as a medical consultant is a trend which has much to offer and should be exploited to the mutual benefit of everyone concerned.

ROBERT A. KIMMICH, M.D.

In Memoriam --- Doctors of Hawaii --- V

This is the fifth installment of In Memoriam—Doctors of Hawaii.

In the cases of many of these early doctors, information is very sketchy. Mrs. Robert Y. Katsuki, chairman of the committee which compiled these sketches, would be grateful to be informed of any errors, either of omission or commission.

James R. Dower

Dr. James R. Dower was formerly of Lahaina, Maui. From the Islands he went to South Carolina for his health and died February 27, 1871, at Aiken, South Carolina.

J. B. Saunders

Dr. J. B. Saunders, a native of Kentucky, died at Wailuku, Maui, on August 16, 1873. He was about 35 years of age.

While he had arrived in the Islands only two years prior to his death, he had many warm friends on Hawaii and Maui.

Dr. Saunders was married and had one child.

He was a Mason.

George Trousseau

George Trousseau was born in Paris May 1, 1833. He was the son of the distinguished Dr. Trousseau who was for many years leader in the profession of medicine and surgery in Paris and an author of many standard medical works.

George graduated at an early age from the Ecole de Médecine of Paris. He served with the French Army in Algiers in the late '50s and in northern Italy at Solferino and Magenta. In 1866 he went to Australia and New Zealand.

Arriving in Honolulu from New Zealand in May, 1872, he took service with the Board of Health, Dr. F. W. Hutchinson being president at the time. Dr. Trousseau was given entire charge of arrangements for treating the smallpox epidemic which had just been introduced in Honolulu from San Francisco. He soon had the epidemic stamped out with a total of 37 cases and 18 deaths.

In 1877 he sold out his practice to Dr. Hutchinson and spent the next two years raising sheep on a farm which he bought in Kona, Hawaii. In 1879 he sold the sheep farm and started Kukuihaele Sugar Plantation in Hamakua, Hawaii, which he managed very successfully until February, 1882, when he re-established his medical practice in Honolulu and continued to practice until his death.

At various times Dr. Trousseau was physician to the Insane Asylum and Oahu Jail and Barracks, and port physician. In his capacity as chief medical officer of the Board of Health in the management and examination of lepers, an effort was made to segregate lepers at the newly established station at Kalihi. He was also physician and Chamberlain to Lunalilo, and confidant of three other kings and queens.

Dr. Trousseau is credited with having imported some ostriches about 1890 which roamed as far as Waialae Avenue in Kaimuki, although their headquarters were supposed to be Kapiolani Park.

The doctor had been married in Paris and was the father of two sons.

On May 4, 1894 Dr. Trousseau died in Honolulu at the age of 61.

Richard Oliver

Dr. Richard Oliver obtained his professional education at the medical school of Saint Bartholomew's Hospital in London. In 1861 he received his MRCS, England, and LSA.

Dr. Oliver practiced for twenty years on Hawaii. In 1892 he became resident physician at the leper settlement on Molokai, which position he held until 1902.

Dr. Mouritz in his book, *The Path of the Destroyer,* states: "Dr Oliver's long contact with leprosy in Kona and Kau, and later at Molokai, where he did some experimental work, had convinced him that the inoculability of leprosy had yet to be proven. He was, however, an advocate of non-contagion, but my persistent and insidious proselytising won him over to the fold of contagion." Dr. Mouritz also writes of Dr. Oliver, "The last ten years of his life, spent at the leper settlement, added largely to his knowledge of the disease. The copious notes, memoranda and other data on leprosy, which he had accumulated, he had intended to publish; but his last illness and subsequent death prevented this. Whatever books and papers the Doctor possessed were speedily lost or destroyed soon after his death, which occurred three months after he had resigned his office at the Leper Settlement."

Dr. Oliver died in Waikiki on August 12, 1902 at the age of 63.

He was married and had one son.

Nathaniel Bright Emerson

Nathaniel B. Emerson was born in Waialua, Oahu, on July 1, 1839. He was the son of the Rev. John S. and Ursula Sophia Newell Emerson, who came to Hawaii with the Fifth Company of Missionaries, May 17, 1832. The family home was at Waialua, where his father was pastor of the native church.

After an early education at Punahou, Nathaniel went to Williams College, Williamstown, Massachusetts. In the midst of his college career he enlisted in the First Regiment of Massachusetts Volunteer Infantry and was wounded twice at Fredericksburg and once at Chancellorsville. The latter wound healed in time for him to be at Gettysburg where an exploding shell tore off the back of his cap but left him otherwise untouched. Although his enlistment expired before the Richmond

campaign, the regiment remained and he was in all the battles from the Rapidan to Richmond.

Returning to Williams, he took his degree in 1865. In 1868 he received his M.A. He then took medicine at Harvard and at the College of Physicians and Surgeons in New York where he was granted his M.D. in 1869.

In New York Dr. Emerson was associated with Dr. Willard Parker, the eminent surgeon, as student and assistant. For several years he was clinical assistant to Dr. Seguin, professor of nervous diseases at the College of Physicians and Surgeons.

Dr. Emerson remained in New York until 1878. Then, at the invitation of S. G. Wilder, Minister of the Interior of the Kingdom of Hawaii and president of the Board of Health, he returned to the Islands to become general inspector of the "lepers and leper stations." Soon after, he entered private practice in Honolulu.

In 1881 Dr. Emerson married Dr. Sarah E. Pierce. One son, Arthur W. Emerson, was born to the couple.

After the revolution of 1887, Dr. Emerson served as President of the Board of Health until 1890, succeeding Dr. Trousseau. He continued private practice until about 1905 when he became police surgeon, largely to have more time to pursue his Hawaiian studies and writings. This position he held until his death.

Dr. Emerson was an able historian and writer of Hawaiian mythology. His more notable works, all of Hawaii, were a translation of David Malo's great work on Hawaiian lore and customs, 1898; an address to the Historical Society on "Long Voyages of the Ancient Hawaiians," 1893; and *Unwritten Literature of Hawaii,* 1899, published by the Bureau of American Ethnology, Smithsonian Institution.

David Malo was qualified admirably to write of his people, but there were peculiar difficulties in translating the work to English. A clarification of the Hawaiian text was necessary before translating it into English.

Dr. Emerson became interested in Hawaiian folklore when he returned from the mainland. His last work, *Pele and Hiiaka,* was published just prior to his death. The admirable care and patience which he exercised in the preparation of his books was evinced in this last collection of Hawaii stories. The doctor gained many versions of the myth of Pele and Hiiaka and then set himself the task of condensing the facts into one volume, a work that took seven years.

Dr. Emerson died July 16, 1915, at the age of 76 while en route from Alaska to San Francisco on a combined health and pleasure cruise. He was accompanied by his son.

He was a member of the American Social Science Association, American Neurologists' Association, Medical Society, Grand Army of the Republic, member and former president of the Hawaiian Historical Society, charter member of the Polynesian Society, a trustee of Oahu College for 17 years and a member of the library for several years.

Frank Henry Enders

Frank Henry Enders was born in Paducah, Kentucky, on November 27, 1841. His father was a prominent merchant and the owner of a plantation in Louisiana.

His early education was received in Danville, Kentucky.

During the Civil War Frank entered the Confederate Army, soon being promoted to lieutenant. He received a bullet wound in or near the lungs, which was the cause of poor health in later life. Near the end of the war he was taken prisoner and confined at Vicksburg, but shortly after, while being removed, he escaped by jumping into the Mississippi River and effecting a landing at Cairo, Illinois. After many privations, he managed to reach his home in Kentucky.

At the end of the war he entered Jefferson Medical College at Philadelphia where he studied under the celebrated Dr. Gross. Dr. Enders began the practice of medicine at Paducah. It was in the same city that he married Miss Lizzie Sanders.

Poor health forced him to give up medicine and enter the drug business, and he soon moved to Cape Girardeau, Missouri. Following a severe illness, he went to St. Louis.

In 1873 Dr. Enders came to Wailuku, Maui, where he bought out the government position of Dr. Brooks and settled down.

He was the originator of the Alden Taro and Fruit Drying Co., having purchased the patent. Mr. A. Barnes became his business partner.

Dr. Enders died November 29, 1884, at Wailuku, just after his forty-third birthday.

The following is quoted from the *Hawaiian Gazette* of December 17, 1884: "To his wise care and forethought we owe it that the hospital for the sick poor is a flourishing institution and carefully attended by the noble and devoted band of sisters whom his influence brought here. How dear that good cause was to his heart was manifest in his last conscious moments, being perhaps his last dream as the last movements of his lips seem to have indicated."

C. R. Moffett

Dr. C. R. Moffet, late of Wailuku, Maui, died at Dallas City, Illinois, on July 10, 1877.

Jared Knapp Smith

Jared Knapp Smith was born December 23, 1849, at Koloa, Kauai, the son of Dr. James William and Melicent (Knapp) Smith. His father was a missionary doctor in Kauai for 45 years.

Young Smith graduated from the College of Physicians and Surgeons in 1876.

Returning to Kauai, Dr. Smith practiced with his father until the latter's death in 1887. For many years he served as government physician.

In 1896 Dr. Smith was engaged to Miss Brewster, former principal of Punahou Preparatory School. Their wedding was scheduled to take place when Dr. Smith was shot on September 24, 1897, in Koloa. The doctor was within a few months of his forty-eighth birthday at the time of his tragic death.

Testimony at the subsequent trial revealed that relatives of a mother and daughter ordered by Dr. Smith to report to Honolulu as leper suspects killed the doctor to prevent the order's being carried out.

An editorial written about Dr. Smith in the *Pacific Commercial Advertiser* of September 27, 1897, says in part: "For years he and his sister have devoted their lives to educating Hawaiians. For this cause, they have given both their service and of their private incomes, often at a personal sacrifice. Until Friday it was not known that he had an enemy in the world. In public he was the exponent of philanthropy and morality. In private, he was faithful to the principles which he taught. Of singular gentleness and sweetness of disposition, he stood as a type of the Christian gentleman."

(*Continued on page 192*)

Bureau of Medical Economics

Dependents' Medical Care Act

The Hawaii Medical Association has elected to act as its own fiscal agent for the implementation of the [Military] Dependents' Medical Care Program.

How many dependents this will bring to civilian doctors in Hawaii is still being debated; however, certain facets of the law (Public Law 569) and the regulations set up to implement the law are presented here for your information.

The purpose of this Act as laid down by the Congress of the United States is as follows:

> The purpose of this Act is to create and maintain high morale throughout the uniformed services by providing an improved and uniform program of medical care for members of the uniformed services and their dependents.

Uniformed services means the Army, the Navy, the Air Force, the Marine Corps, the Coast Guard, the Commissioned Corps of the Coast and Geodetic Survey, and the Commissioned Corps of the Public Health Service. The dependents that may be eligible for civilian medical care are the lawful wife or the dependent lawful husband (spouses), and children who are dependents of members of the uniformed services.

The dependent in some cases has a free choice of whether he or she goes to civilian or military medical facilities. Dependents who are eligible for civilian medical care and who are not residing with their sponsors shall have free choice between uniformed services medical facilities and civilian medical facilities. Dependents eligible for civilian medical care who reside with their sponsors shall have free choice, except that the Secretary of a uniformed service may require such dependents in a prescribed area to seek medical care in a uniformed service medical facility if he finds that:

1. The uniformed services medical facilities are adequate to care for the dependents of the members assigned to that area, and
2. The use of civilian medical facilities by the dependents in that area has affected adversely, or may affect adversely, the optimum economic utilization of the uniformed services medical facility.

It should be pointed out here that the dependents who are eligible for civilian medical care, save for a few exceptions, are eligible for inpatient care *only*. Interpretation of the law reads as follows:

Medical Care Authorized from Civilian Sources

Medical and surgical care from civilian sources is authorized for spouses and children who are dependents of members of the uniformed services for the following:

a. Treatment of acute medical conditions, including acute exacerbations or acute complications of chronic diseases, only during hospitalization, except as otherwise provided . . .

b. Treatment of surgical conditions, only during hospitalization, except as otherwise provided . . .

c. Treatment of contagious diseases, during hospitalization.

d. Complete obstetrical and maternity care.

e. Three hundred sixty-five days' hospitalization in semi-private accommodations for each admission, including all necessary services and supplies furnished by the hospital during hospitalization.

f. Services required of a physician or surgeon prior to and following hospitalization for a bodily injury or surgical operation.

g. Treatment in a hospital of acute emergencies of any nature which are a threat to the life, health, or well-being of the patient, including acute emotional disorders. Hospitalization is authorized at Government expense for such emergencies only, pending completion of arrangements for care elsewhere.

h. Diagnostic tests and procedures including laboratory tests and pathology and x-ray examinations incident to hospitalization when ordered by the attending physician.

As you can see from the above, outpatient care at government expense for dependents eligible for civilian medical care is not authorized from civilian sources, except as outlined in d, f, and h above.

Specifically, medical care listed below will not be authorized for any of the following:

a. Chronic diseases
b. Nervous and mental disorders
c. Elective medical and surgical treatment
d. Domiciliary care.
e. Treatments or procedures normally considered to be outpatient care.

The method for identifying eligible dependents, instructions on how to file a claim form, and the fee schedule will all be distributed to the doctors of Hawaii prior to the effective date of this program. (December 7, 1956).

There are many other facets of the Dependents' Care Program, such as a deductible feature on hospital charges, limitations on the dollar amount of diagnostic tests and procedures, consultant fees,

(*Continued on page 223*)

The Honolulu County Medical Library

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Recent Acquisitions

Biochemistry

Lakeside Laboratories *Of water, salt and life.* c1956. (gift of publisher)
Luck, J. M., ed. *Annual review of biochemistry.* v.25. 1956.
Springer, G. F., ed. *Polysaccharides in biology. Trans. . . 1st conf., April 27-29. 1955.* c1956. (gift of Josiah Macy, Jr. Foundation)

Blood and Heart

Abrams, H. L. *Angiocardiographic interpretation in congenital heart disease.* c1956. (gift of publisher)
Martin, Peter, ed. *Peripheral vascular disorders.* 1956.
Samuels, S. S., ed. *Diagnosis and treatment of vascular disorders.* c1956.
Tocantins, L. M., ed. *Progress in hematology.* v.1. c1956. (gift of publisher)
Wolff, Louis *Electrocardiography.* 2nd ed. c1956. (gift of publisher)

Cancer

Ivy, A. C. *Observations on Krebiozen in the management of cancer.* c1956. (gift of author)

Dermatology

Pillsbury, D. M. *Dermatology.* c1956. (gift of publisher)

Endocrinology

Pincus, Gregory, ed. *Recent progress in hormone research.* v.11. c1955.
Wolstenholme, G. E. W., ed. *Ciba Foundation colloquia on endocrinology.* v.9. 1956. (gift of Ciba Foundation)

Geriatrics

Wolstenholme, G. E. W., ed. *Ciba Foundation colloquia on ageing.* v.2. 1956. (gift of Ciba Foundation)

Lung

Rubin, E. H. *The lung as a mirror of systemic disease.* c1956. (gift of publisher)

Medical Economics

Massachusetts Memorial Hospitals *Health for the American people.* c1956. (gift of publisher)
Stern, B. J. *American medical practice.* c1945. (gift of Public Health Comm., Chamber of Commerce)
Stern, B. J. *Medical services by government.* c1946. (gift of Public Health Comm., Chamber of Commerce)
Stern, B. J. *Medicine in industry.* c1946. (gift of Public Health Comm., Chamber of Commerce)

Neurology & Psychiatry

Abramson, H. A., ed. *Neuropharmacology, Trans. . . 2nd conf., May 25-27, 1955.* c1956. (gift of Josiah Macy, Jr. Foundation)
Barrow, R. L. *Epilepsy and the law.* c1956. (gift of American League Against Epilepsy)
Haymaker, Webb *Bing's local diagnosis in neurological diseases.* Trans., rev. & enl. from 14th German ed. c1956.
Lewis, N. D. C., ed. *Studies in topectomy.* c1956. (gift of publisher)
Liddell, H. S. *Emotional hazards in animals and man.* c1956. (gift of publisher)
Rado, Sandor, ed. *Changing concepts of psychoanalytic medicine.* c1956. (gift of publisher)
Rado, Sandor *Psychoanalysis of behavior.* c1956. (gift of publisher)
Rhine, J. B. *New world of the mind.* c1953.
Ulett, G. A. *A synopsis of contemporary psychiatry.* c1956. (gift of publisher)
Wolstenholme, G. E. W., ed. *Ciba Foundation symposium on extrasensory perception.* 1956. (gift of Ciba Foundation)

Nursing

Barschak, Erna *Today's industrial nurse and her job.* c1956. (gift of publisher)
Ferguson, I. L. *The mathematics of dosages and solutions for nurses.* c1956. (from Nurses' Association)
Frobisher, Martin *Microbiology and pathology for nurses.* 4th ed. c1956. (from Nurses' Association)
Frobisher, Martin *Microbiology for nurses.* 9th ed. c1956. (from Nurses' Association)
Fuerst, E. V. *Teaching fundamentals of nursing.* c1956. (from Nurses' Association)
Goodale, R. H. *Nursing pathology.* 2nd ed. c1956. (from Nurses' Association)
Millard, N. D. *Human anatomy and physiology.* 4th ed. c1956. (from Nurses' Association)

Orthopedics

Bohler, Lorenz *The treatment of fractures.* v.1. c1956. (gift of publisher)
De Palma, A. F., ed. *Clinical orthopedics.* No. 7. c1956.
Hadley, L. A. *The spine.* c1956. (gift of publisher)
Piulachs, P. *Ulcers of the legs.* c1956. (gift of publisher)

Pathology

Armed Forces Institute of Pathology *Atlas of tumor pathology Sec. III, Fasc. 7; Sec. V, Fasc. 19; Sec. IX, Fasc. 33.* c1956. (gift of A.F.I.P.)

(Continued on page 212)

Book Reviews

Controlled Hypotension in Anesthesia and Surgery.

By David M. Little, Jr., M.D., 159 pp., Price $4.50, Charles C. Thomas, 1956.

This monograph is largely concerned with the physiological phenomena associated with induced hypotension during anesthesia and surgery. It is a scientific treatise which will be too complex to interest the average clinician but a "must" for those specializing in anesthesia or those who plan to use hypotensive techniques in their surgical practice.

JAMES W. CHERRY, M.D.

Psychopathy and Delinquency.

By William and Joan McCord, 230 pp., Price $6.50, Grune & Stratton, 1956.

The title of this book is somewhat misleading. Of course, psychopathy is always an important factor in the overall problem of delinquency but the problem of delinquency enters only incidentally into the McCords' discussion of psychopathy. William and Joan McCord have done a thorough and scholarly job of bringing together the theoretical thinking and experimental work done over a wide span of years on the problems arising in the diagnosis and treatment of psychopathy. Their attempts to reconcile experimental findings into meaningful and useful theory and practice should be very stimulating to professional people who have to make diagnoses of psychopathy and treat this condition. The authors also discuss the need for more changes in the philosophy of law and punishment as it applies to the psychopath. The thinking behind this discussion should be informative to the layman as well as to the professional worker, but it is doubtful that a layman would find this particular book stimulating. It is obviously written primarily for professional people in the fields of medicine, social science, and law.

FRED E. LA FON, Ph.D.

Angiocardiographic Interpretation in Congenital Heart Disease.

By Herbert L. Abrams, M.D., and Henry S. Kaplan, M.D., 238 pp., illustrated, Price $11.75, Charles C. Thomas.

This book is divided into two parts, the first covering the historical background of angiocardiography, the techniques, contrast media and roentgen equipment employed, and the general principles of interpretation, and the role of aortography in diagnosis.

The second part is divided into 27 sections, each dealing with specific congenital cardiac anomalies. The pathology, physiology, clinical, laboratory and electrocardiographic aspects, conventional roentgenographic findings and cardiac catheterization data in each malformation are summarized at the beginning of each chapter and followed by description of angiocardiographic findings. These data are beautifully supplemented by roentgenographic reproductions and descriptive line drawings.

This book would make an excellent addition to the library of anyone interested in congenital heart disease.

SCOTT C. BRAINARD, M.D.

Urological Surgery.

By Austin Ingram Dodson, M.D., 868 pp., illus., Price $20.00, C. V. Mosby Co., 1956.

This is the third edition of the leading text book on urological procedure in America today. For the most part, there is little change in this writing from the previous edition, there being very complete anatomical reviews covering each system. Treatment of tuberculosis and renal calculi are brought up to date and surgical approaches of a new nature are included. Each section is written by a leading professor in the urological field. The references are complete in every detail.

Every man specializing in urological surgery should have this edition at his finger tips. For the occasional urologist, it would be a worthwhile part of his reference armamentarium.

ANDREW L. MORGAN, M.D.

The Drug Addict as a Patient.

By Marie Nyswander, M.D., 179 pp., Price $4.50, Grune & Stratton, Inc.

In this short and readable book Dr. Nyswander deals in a remarkably comprehensive fashion with the problem of drug addiction.

The topics covered include the pharmacology of addicting drugs and their physiological effects, carefully outlined methods of withdrawal, psychological factors, and rehabilitation measures. Also included is an enlightening historical account explaining how the drug addict has come to be considered a criminal rather than a medical problem in the United States.

She injects a tone of real hope, too seldom seen, in the treatment of this condition. Physicians everywhere would do well to read this book, and to consider whether the return of drug addiction to the province of medicine, under carefully controlled conditions, might not be more effective for the public good than increasingly punitive measures.

KENNETH H. RUSCH, M.D.

Pediatric Dermatology.

Pediatric Clinics of North America—Aug. 1956, 347 pp., illustrated, W. B. Saunders Co., 1956.

This volume discusses various skin conditions found in infants and children. The authors have noted the peculiarity of the skin of the infants and children which differs from those of adults anatomically, physiologically, and pathologically and hence responds differently to management.

This book is written primarily for physicians who treat babies and children and is concise but comprehensive in this area.

The authors on page 506 state that "serious consequences may occasionally result from this otherwise benign pyoderma . . . rheumatic fever being the most significant." In the experience of this reviewer rheumatic fever is preceded by angina and not pyoderma.

This book is recommended for pediatricians and general practitioners who see children in their practice.

TERUO YOSHINA, M.D.

(Continued on page 217)

HMSA—Its Place in the Community

Coordination—An Important Service

J. R. VELTMANN, *Executive Vice-President*

Over three million, five hundred thousand dollars ($3,500,000.00) is the amount HMSA expects to pay doctors and hospitals for services rendered its members during 1956. This means processing over 180,000 individual claim forms representing approximately 15,000 individual financial transactions a month. This tremendous volume of business transactions brings close daily contacts between HMSA, the doctors, and hospitals. Necessary administrative machinery is geared to price, code, and process claims within 48 hours after they are received at HMSA. The essential element of coordination to assure prompt and accurate settlement of each claim is the Medical Director and the Service Consultant of the Association.

The Medical Director, a physician, represents both the medical profession and HMSA on a full-time basis. He is the liaison officer between doctors and the Association. He is responsible for all matters pertaining to the technical and professional aspects of the claims administration of the plan. He personally reviews each claim requiring individual consideration and expedites the processing of such claims by discussing the cases with the physician. In determining an adequate fee for an unscheduled service, he consults surgical fee schedules of mainland Blue Shield Plans and arrives at a fee which is satisfactory to the attending physician. Such new fees are recorded and from time to time referred to the Fee Adjustment Committee of the Medical Society for consideration as an addition to the Fee Schedule.

In the course of his daily routine, the Medical Director is available to discuss individual problems personally with physicians at his HMSA office and quite frequently visits them at their office to review the progress of the plan. New physicians participating in the HMSA program are invited to the HMSA office for a personal tour of the business operation and for a thorough review of the objectives and administrative procedures of the Association. He occasionally meets with all county medical societies to review the progress of the plan. All controversial claims or policy matters are presented by him to the Medical Committee, which is composed of all physician members of the Board of Directors, for necessary action.

While the Medical Director coordinates activities with the professional men, the Service Consultant, a field representative, works with the doctors and hospital business office personnel. A few of the functions of the Service Consultant are:

1. *New Doctors.* When word is received from the Medical Society that a doctor wishes to participate in the HMSA program, the Service Consultant arranges an initial visit with the doctor and his office staff for an orientation discussion on HMSA. She provides him with an HMSA *Physician's Manual,* reviews the various plans and benefits being offered to members, and explains administrative procedures with special emphasis on claim procedures. She supplies him with brochures and literature outlining facts about the Association for distribution to his patients and claim forms for billing HMSA cases. If the doctor is interested, she also has an outline of a simplified accounting procedure which represents a composite of many successful systems in use by local doctors. After the initial meeting, the Service Consultant is frequently invited back by the doctor for further information.

2. *New Office Personnel.* We encourage physicians to send their new office personnel to HMSA for an indoctrination or basic understanding of HMSA operations and to learn billing procedures. The Service Consultant conducts a tour of the various departments of the plan and introduces them to key personnel with whom they will have future contact. This service has proved very successful and employees do not hesitate thereafter to call HMSA for clarification of any phase of our operations which they do not fully understand.

3. *Seminars.* When a new procedure or new plan is developed, HMSA has found through experience that the best method for providing information to all doctors and hospital personnel handling HMSA claims is through group meetings. During the past few years, several types of meetings have been called, but the most successful have been early morning conferences. Our "Coffee and Doughnuts" seminars have been well attended; at a recent one over 125 representatives of doctors, hospitals, and laboratories learned the details of a new plan. A healthy discussion period following the presentation clarified many points. Group seminars are scheduled at various locations in the Territory for the convenience of personnel invited to attend.

4. *Visits.* The Service Consultant spends several hours each day visiting doctors' offices and hospitals to assist them wherever necessary in connection with HMSA. On these routine visits she will replenish the supply of brochures and literature about HMSA. Her visits include all areas in the Territory of Hawaii, and all doctors and hospitals are encouraged to call on her for assistance.

The close coordination of the Medical Director and the Service Consultant with physicians, their office staffs, and hospital business office personnel has proved the time-tested theory—better understanding resolves many problems.

Woman's Auxiliary

Goals and Accomplishments

Eight years ago the doctors invited their wives to form this auxiliary, patterned after and affiliated with the Woman's Auxiliary to the American Medical Association. Since the Hawaii Medical Association is the group we are to support it must judge the degree to which we have helped.

Objectives:

1. **To extend the aims of the medical profession to all organizations which look to the advancement of health and health education.**

"All" makes this an infinite goal. Surely, we rate a plus for effort even though we have not covered the field.

2. **To cultivate friendly relations and promote mutual understanding among physicians' families.**

This seems to be our outstanding success.

3. **To participate in programs on the request of the Hawaii Medical Association.**

We hope our efforts have helped. Since we are an auxiliary we only participate "on the request of the Hawaii Medical Association."

4. **To coordinate and generally to direct the activities of component auxiliaries.**

Since each county auxiliary acts solely upon the direction of its doctors' advisory committee, coordination is dependent on the parent organization.

5. **To assist in the entertainment at all conventions of the Hawaii Medical Association.**

100%. Does anyone disagree?

"On the request of the Hawaii Medical Association" is the determining factor of our activities. The portions of the National Auxiliary program which we have been asked to undertake are:

1. *Today's Health,* magazine (1948 to date)
2. Mental Health (1955 to date)
3. American Medical Education Foundation (1956 to date)

The promotion of *Today's Health* has been continuous. Among doctors and dentists it should be merely routine subscription business for their offices; however, some doctors are not much interested in this publication. Unless it has the support of these men and women, the general public will remain indifferent to its sound advice and informative articles. Our committees will continue efforts to acquaint more people with this excellent magazine.

During the time he was H.M.A. president, Dr. Clarence E. Fronk and the advisory committee asked the Woman's Auxiliary to inaugurate in Hawaii the program on Mental Health recommended by the national auxiliary. Dovetailing into this program, the speaker for the auxiliary annual luncheon meeting was Commander Harry A. Wilmer, M.C., U.S.N.R., whose subject was "People Need People." Honolulu Auxiliary has sponsored two meetings with programs on this theme. Maui Auxiliary has approved such a project. County advisory committees should make recommendations to their local auxiliaries whether or not to join the territorial effort in this interest.

American Medical Education Foundation, long a project of the W.A.A.M.A., crept into the latest recommendation from H.M.A. in an unpremeditated manner. Recent promotional material from national headquarters to individual auxiliary members urged them to solicit funds from their lay friends for this worthy project. The matter was referred to the advisory committee. The doctors decided that we should not request contributions from persons not connected with the medical profession. Having decided not to follow the plan urged by national, it was recommended that further efforts be made to have every doctor a contributor and that the auxiliaries were just the ones to make this succeed.

The program recommendations of the advisory committee have been made to each county medical society president and advisory committee chairman, and each county auxiliary president. If all islands participate, the results will be most satisfactory.

Many other programs are sponsored by W.A.A.M.A., for which literature and suggestions are available to any auxiliary. Our program chairman, Mrs. Tofukuji, will report on these in future articles so that auxiliary members and doctors may learn of the achievements of auxiliaries all over the mainland.

New Chairmen

It is a pleasure to announce two new committee chairmen for the W.A.H.M.A.:

(Continued on page 189)

County Society Reports

Honolulu

The regular monthly meeting of the Honolulu County Medical Society was held Tuesday, September 4, 1956, at 7:30 P.M. in the Mabel Smyth Auditorium. Dr. J. M. Felix presided and approximately 52 members were present.

A short colored movie, "Cancer of the Lung," was presented through the courtesy of the Hawaii Cancer Society, followed by a brief review of the film by Dr. Walter Quisenberry. Dr. W. J. Holmes presented a talk entitled "Medical Mission to the Orient and Australia."

New members who were welcomed into the Society were: Drs. Varian Sloan, George Susat, Robert Rigler, Frederick B. Warshauer, Christopher Bull, Leabert Fernandez, and Philip Watt.

It was announced that Thursday, September 6, 1956, was the last day to register for voting. Also the members were informed that only 33% of the Fee Survey Questionnaires had been returned and those who had not completed theirs were asked to do so at once.

Elections

The following old business was brought up for discussion: In May, at the regular membership meeting, Dr. Richard Ando submitted an amendment to the Constitution and Bylaws Committee's recommendation "that the officers, President-elect, Secretary, and Treasurer, shall be elected by a majority vote and all other officers be elected by a plurality vote," amending it to read "that all officers be elected by a majority vote." This latter amendment and motion were referred back to the Board of Governors who in turn referred them back to committee. The Constitution and Bylaws Committee then reaffirmed their original recommendation and so reported back to the Board of Governors. The Board of Governors, after a thorough review of the subject, upheld Dr. Ando's amendment.

Before discussion was started Dr. Felix announced that in view of the fact this amendment may cause some complications as far as elections are concerned, it was decided, upon Dr. Ando's recommendation, that if the membership should approve the amendment, elections would be handled by a mail ballot.

In answer to questions asked about nominations from the floor, Dr. Felix explained that the ballots will be sent out to members after nominations from the floor are made at the November meeting.

A lengthy discussion ensued and the following points were brought out:

In answer to a question "if this was to be a secret ballot, how would it be known if the voter was from the Society?" it was explained that there would be means of identifying the ballot as an official ballot.

Dr. S. Yee questioned the ability of a mail ballot to solve the problem and asked if none of the nominees received a majority vote, what would happen. The Chair explained that the nominee receiving the least number of votes would then be dropped and a run off election on the remaining nominees would be held on the night of the annual meeting.

Dr. Ando explained that the point that brought up his amendment was one of principle and felt that those who were elected should be a majority representation and not one of a small minority.

Dr. Moore felt that Dr. Ando had presented some very convincing arguments why we should not vote for his amendment and rules of election. He stated that if a person isn't interested enough in the Society to appear at an election meeting, then he shouldn't have a vote. The idea of holding elections by ballot so we don't have to come to a meeting is a very poor reason.

It was finally moved by Dr. Walsh, and seconded, that action on this question be postponed until after the December meeting. After a short discussion the motion was carried.

A letter from the Program Chairman was read which concerned the annual October fun meeting. After a brief discussion, the membership voted to have a family picnic rather than a stag night. This event will take the place of the regular October meeting.

New amendments to the Constitution and Bylaws were read. No action by the membership was necessary. A complete list of amendments was to be circulated to the membership 10 days before the November meeting.

Upon a suggestion made by our attorney, the Board of Governors recommended that the Medical Society should incorporate. It was pointed out that our Constitution and Bylaws permit the Society to incorporate at any time. The membership moved to approve the Board of Governors' recommendation.

Resolutions in memory of Drs. Frank L. Putnam, William Oscar French, and Mitsuharu Hoshino were read and adopted by a unanimous standing vote.

Medicare

The membership was informed that recently the Council of the Hawaii Medical Association approved the Dependents' Medical Care Program in principle and recommended that HMSA should act as its fiscal agent. Also our Fee Adjustment Committee should work out a fee schedule. The Council was now working for ratification of its action. An outline of the benefits to be offered in the Dependents' Care Program was read to the membership.

Dr. S. Yee advised that this matter was brought before the Council of the Hawaii Medical Association and, after a lengthy discussion, it was decided that the matter should come before the Medical Society for their approval or disapproval. He further stated that the Society and the Hawaii Medical Association should try to take on this job and moved that the Honolulu County Medical Society go on record as favoring the appointment of the Hawaii Medical Association as the fiscal agent through the Bureau of Medical Economics. The motion was seconded.

When asked if the Bureau of Medical Economics could handle this business, Mr. Kennedy stated that first of all it would require additional space. After checking with the Veterans Administration on the amount of work involved in the Veterans' Hometown Care Program with the idea that the Dependents' Medical Care Program may use similar claim methods, Mr. Kennedy stated that if the same or similar methods were used, the Bureau would have no difficulty in handling the work. However, if other methods were used, he was not in a position to say whether or not this would be economically feasible.

(*Continued on page 197*)

Hawaii Medical Association

MINUTES OF MEETING HOUSE OF DELEGATES

October 4, 1956, 7:30 p.m., Mabel Smyth Building

The meeting was called to order by Dr. Boyden and a roll call was taken by the secretary, Dr. Nishijima. Present were officers Drs. Boyden, Yee, Felix, Fleming, Kuhlman, Nishijima, Pang, Fronk; delegates P. S. Arthur, R. G. Benson, Thomas Y. K. Chang, Edmund Ing, L. Q. Pang, Quisenberry, Bailey, Batten, Chinn, Morgan, William H. Stevens, James T. S. Wong, Oto (Hawaii), Burden (Maui), Rockett (Maui), and Kim (Kauai). Three Honolulu delegates did not answer to the roll call and Dr. Felix authorized the following alternates to vote: Drs. Carl Johnsen, Thomas Bennett, and Randal Nishijima.

Minutes of the April 25, 26, and 27, 1956 meetings of the House of Delegates were approved.

DISTINGUISHED SERVICE AWARDS

Dr. Boyden opened the discussion on the matter of criteria for the distinguished service awards by explaining that for the last meeting selection of recipients was made solely by the councilors residing on Oahu and asked for a discussion on how the matter is to be handled in the future. He said it is not necessary to have selections every year but if we do, this year it might be in order for the councilors on Kauai to look over the field.

Dr. Yee questioned if it were the idea of the councilors to have distinguished service awards every year and wanted to know if it were a perpetuating idea.

Dr. Quisenberry asked who is supposed to initiate the proceedings and wanted to know if it were the duty of the councilors.

Dr. Boyden pointed out that there is no precedent other than what happened at the Centennial where the councilors acted in secrecy.

Dr. Batten asked if the suggestion implied that the nominations would be made from the specific island on which the meeting is to be held and that the other islands would not be offering any nominations.

Dr. Boyden explained that it will be eight years before Kauai has the meeting again and that it is possible that some candidates will not be around eight years from now.

Dr. Felix said when Dr. Boyden's letter asking for names was received by the County, this matter was discussed. The Board of Governors felt that some type of criteria should be set forth by the HMA that would somewhat guide the counties in making selections.

Dr. Boyden said that again would depend upon the islands from which the choice would be made.

Dr. Felix said that maybe the awards should be given on the basis of service.

Dr. R. Nishijima added length of service.

Dr. Batten questioned if the suggestion meant solely on the years of service.

Dr. R. Nishijima said "Yes."

Dr. Batten felt that wouldn't make much out of the awards.

Dr. Boyden pointed out that last year the awards were not confined to medical men only.

Dr. Fronk said he thought that a committee should be appointed to give the matter study and set up the criteria and moved that Dr. Boyden appoint a committee to set up the criteria.

Dr. Batten said for the aid of the committee he thought we should have some more discussion.

Dr. Yee understood that last year the issuing of these awards was supposed to be a unique item in our Centennial celebration and wondered if these awards should be a continuing thing. If a committee is appointed, they would take that into consideration.

Dr. Quisenberry said the question of whether it should be an ad hoc committee or a standing committee should be considered.

Dr. Fronk felt that it should be a special committee and that the criteria set up can stand for all time.

Dr. Stevens wondered if this same committee should function in the selection of candidates and if there would be a similar body to pass on these candidates.

Dr. Felix said that would depend upon the report of the committee.

Dr. H. Q. Pang explained that the program was started by the councilors and they did not have any real criteria. They had a meeting at the Pacific Club and certain individuals were nominated and the final decision was made right then and there. It was not their intention that a distinguished service award be made every year.

Dr. Yee said that since none of the delegates had been instructed on this sort of thing and the matter is being originated in the House of Delegates, the report should be made back to the House of Delegates.

Dr. L. Q. Pang said that in order to facilitate the matter he should like to put forth a motion. He moved that the president appoint a committee to study the matter and set up the criteria for the distinguished service awards and that this committee report back to the House of Delegates at the next meeting, setting forth these criteria.

Dr. Fronk seconded the motion which passed unanimously.

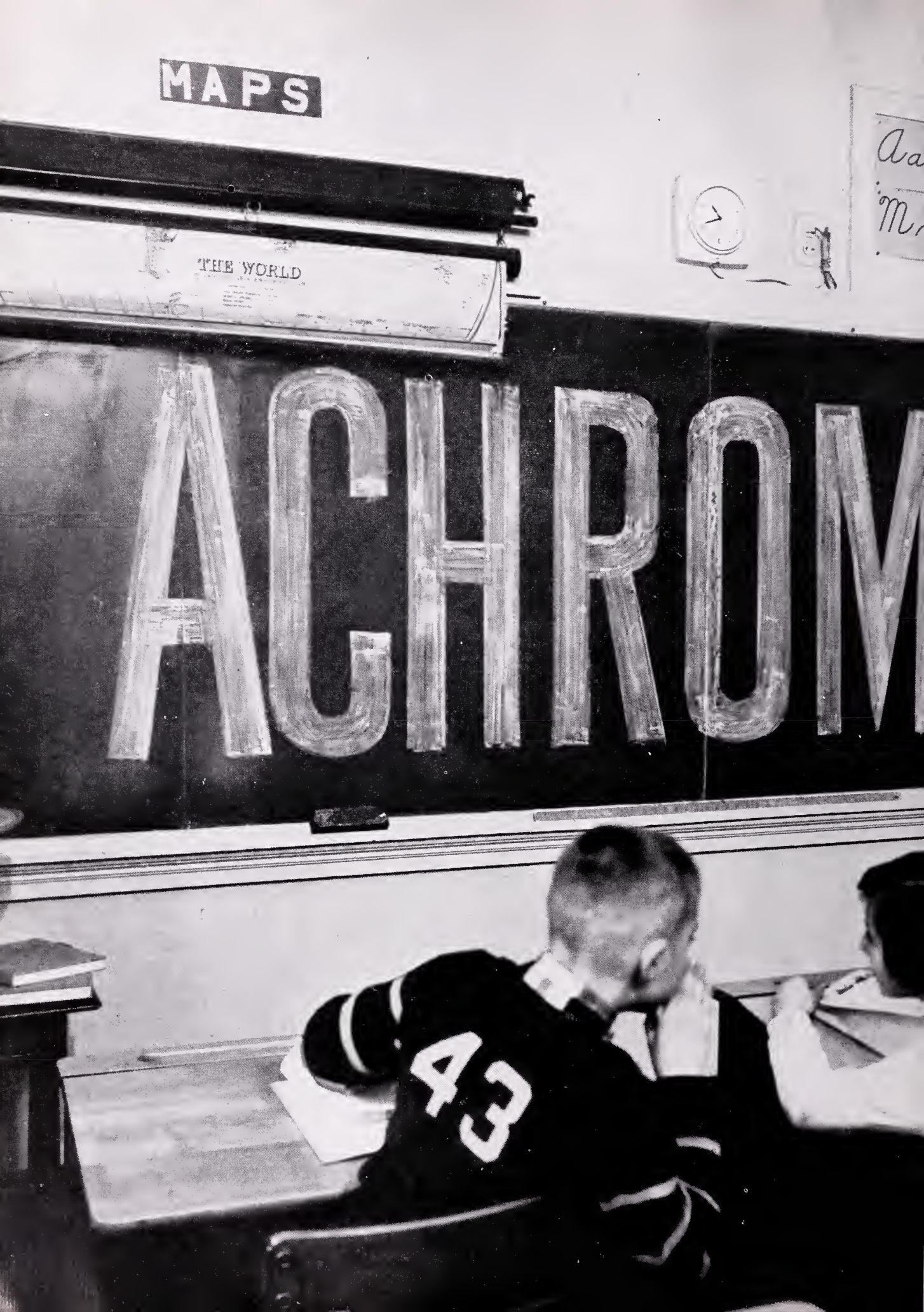
CHRONIC ILLNESS COMMITTEE

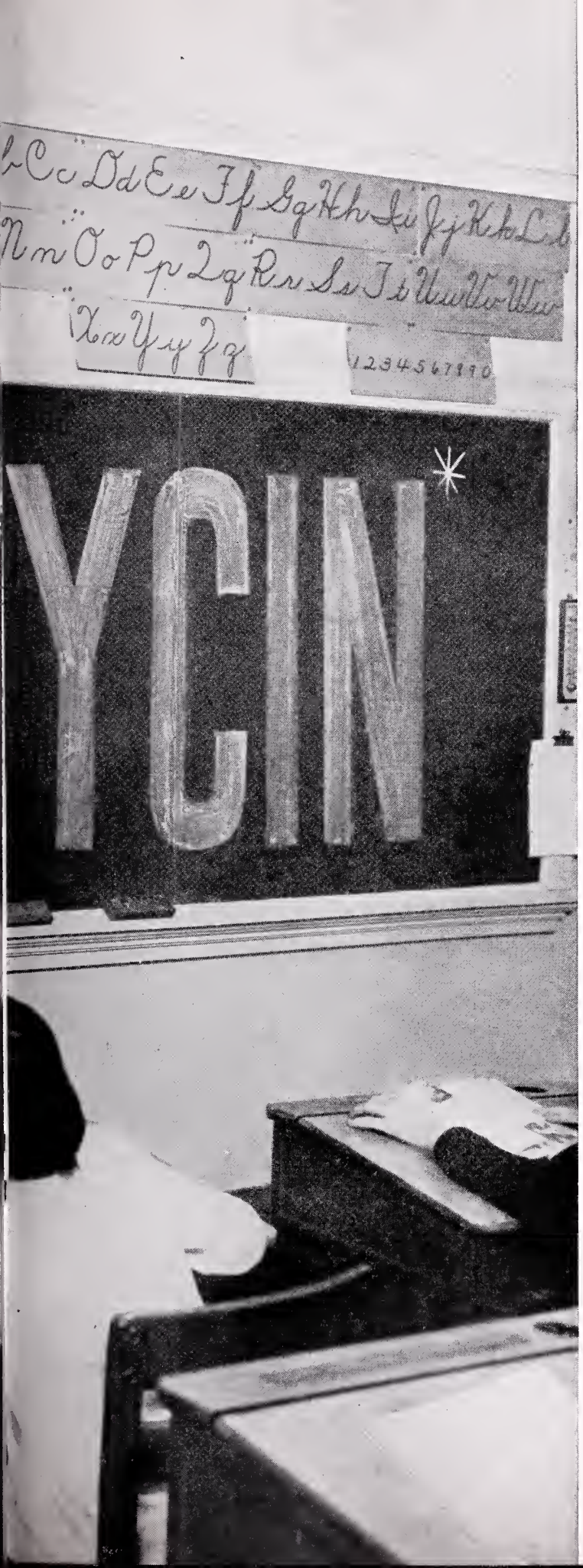
Dr. Boyden said the Chronic Illness Committee had done more work than any three or four committees that have ever been appointed and asked for an expression from the chairman.

Dr. Mills explained that when Dr. French was still chairman they were all given certain phases of chronic illness to report on. His part was to study the facilities we have for home treatment. Dr. Walker studied facilities for tubercular patients. Dr. Kimmich for psychiatric, etc. The study was done superficially because after looking into the matter it was obvious that it would take a long time, money, and secretaries to compile the data. Dr. Walker had stated he would like to know whether or not the data would be used, and would it be feasible to go ahead with a long range program. Until the committee finds out what is to be done with the material collected, it was decided to hold further study in abeyance.

Dr. Quisenberry said that he was with the Health Department at the time Dr. Wilbar asked for the ap-

(*Continued on page 201*)


MAPS
THE WORLD
ACHROM
43



ACHROMYCIN*

Hydrochloride
Tetracycline HCl *Lederle*

in the treatment of

respiratory infections

January and his associates[1] have written on the use of tetracycline (ACHROMYCIN) to treat 118 patients having various infections, most of them respiratory, including acute pharyngitis and tonsillitis, otitis media, sinusitis, acute and chronic bronchitis, asthmatic bronchitis, bronchiectasis, bronchial pneumonia, and lobar pneumonia. Response was judged good or satisfactory in more than 84% of the total cases.

Each month there are more and more reports like this in the literature, documenting the great worth and versatility of ACHROMYCIN. This modern antibiotic is unsurpassed in its range of effectiveness. It provides rapid penetration, prompt control. Side effects, if any, are usually minimal.

No matter what your field or specialty, ACHROMYCIN can be of service to you. For your convenience and the patient's comfort, Lederle offers a *full* line of dosage forms.



For more rapid and complete absorption. Offered only by Lederle!

[1]January, H., *et al.*: Clinical Experience With Tetracycline. In: *Antibiotics Annual*, 1954-55, Medical Encyclopedia, Inc., New York, N.Y., 1955, p. 625.

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Notes and News

MAXWELL DELMORE BOYD, M.D.
1904-1956

Maxwell D. Boyd was born at Bar Mills, Maine, on March 2, 1904, the son of Oscar Stuart and Christina Mack Boyd. He died at Hana, Maui, on August 5, 1956.

He attended Shelburne Academy in Nova Scotia, Canada, and was graduated from Somerville, Massachusetts, High School. He was a graduate in the engineer division of the Massachusetts Military Academy. Dr. Boyd took his pre-medical training at Tufts University and received his medical degree from the Boston College of Physicians and Surgeons in 1937.

Following graduation he served one year in a rotating internship at St. Luke's Hospital, Newburgh, N. Y., and then taught physical diagnosis at the Boston College of Physicians and Surgeons for one school year. Dr. Boyd served as assistant resident in otology at the Royal Victoria Hospital, Montreal's McGill teaching hospital, and one year as resident in ophthalmology and otolaryngology.

Dr. Boyd was licensed to practice in the Territory of Hawaii in 1953 and opened his office for general practice in Wailuku, Maui, in March, 1954. In June, 1955, Dr. Boyd was appointed County Physician for the Hana District on Maui. In March, 1956, he took the course in clinical electrocardiography at the University of California Medical Center in San Francisco.

Dr. Boyd was a member of the medical group instrumental in establishing a chapter of the American Academy of General Practice in Hawaii. He was also a member of the Interstate Postgraduate Association. He was a charter member of the Hawaii St. Andrew's Society.

Dr. Boyd married the former Iola Solem in Augusta, Georgia, in May 1949. They came to the Islands in January of 1950 where Dr. Boyd served at Tripler Army Hospital as Chief of the Physical examination service and Port Surgeon for the Honolulu Army Port. Earlier military service consisted of duty at Fort Huachuca, Arizona; Camp Polk, Louisiana; South Pacific Theater; Hospital ships "Comfort" and "Mercy" in the Atlantic; Oliver General Hospital at Augusta, Georgia; and then Tripler Army Hospital. He was separated from the service as a major in the Army Reserve in August, 1953.

Dr. Boyd was active in community affairs. He was about to begin his second term as president of the Hana P.T.A. and had just been appointed physician and chaplain for the Hana C.A.P. In May of this year Dr. Boyd was licensed as a lay preacher in the Congregational Christian Churches of Hawaii and had preached often in Hana's Wananalua Church as well as in other Maui churches.

Dr. Boyd is survived by his wife, Iola, and two daughters, Kari Christine-Gael, 6, and Iola Margaret-Gael, 4, and a sister, Helen Boyd of Palo Alto, California.

PERSONALS

New . . .

. . . offices

Dr. Ruth Sisan moved her offices to 465 South Beretania Street.

Dr. Marian Hanlan assumed the duties of school physician at the Kamehameha Schools.

Dr. Richard S. F. Lam announces his return from active military service and the reopening of his office at 1231 South Beretania Street.

Dr. Bernard W. D. Fang announces the opening of his office at the Medical Dental Building on Kukui Street. Dr. Fong is a graduate of St. Louis College, Bucknell University and Jefferson Medical College. He recently completed a teaching fellowship in cardiovascular diseases at Jefferson Medical College Hospital. He is limiting his practice to internal medicine.

Dr. William M. H. Dung announces the opening of the Kaneohe Medical Center, 46-003-C Kamehameha Highway.

Dr. Ichira Nadamoto announces the opening of his office in the Young Hotel Building with practice limited to orthopedic surgery.

Dr. Alan K. Luning announces his association with the Fronk Clinic at Kahuku, Oahu.

. . . resident

Dr. Yashiki Ushiyama is one of the new resident psychiatrists at the Territorial Hospital, Kaneohe.

. . . appointment

Dr. Glenn N. Yanagi has been appointed City and County Medical Officer to Waianae and Nanakuli district.

. . . officers

Dr. Harold M. Chandler of Waipahu has been elected President of the American Medical Association of Vienna, Austria.

At a recent election, the Honolulu Obstetrical & Gynecological Society named the following officers: **Dr. Radney G. West,** President; **Dr. Jack S. Woodruff,** Vice-President, and **Dr. Fugate Carty,** Secretary-Treasurer.

The new officers announced at the annual meeting of the Hawaii Heart Association, Inc., are: **Dr. Martan E. Berk,** President; Mrs. W. Janney Hull, 1st Vice-President; Mr. Fritz K. Kleene, 2d Vice-President; Brig. Gen. (Ret.) K. J. Fielder, 3rd Vice-President.

. . . associate

Dr. William Stevens announced the association of **Dr. Stanley Standal** in the practice of psychiatry and counseling.

. . . society

The Hawaii Catholic Physicians Guild was recently organized "to uphold and promote principles of Christian society and the Catholic faith as they are related to sciences and practice of medicine." **Dr. Jahn M. Felix** is President, **Dr. A. Leslie Vascancellos** is Vice-President, and **Dr. Richard K. Chun** is Secretary.

. . . bride

Mr. and Mrs. William H. Johnston of Kingsport, Tennessee, announced the engagement and forthcoming marriage of their daughter, **Dr. Mary Elizabeth Johnston,** to Mr. David M. Bray. The wedding will take place on November 17 at the First Methodist Church in Honolulu.

. . . daughter

Dr. and Mrs. Robert M. Brown announced the birth of a daughter, their third child, Sharon Puulani, on July 28 at the Tokyo Army Hospital.

. . . grandfather

Dr. F. J. Pinkerton of Honolulu and Mrs. M. C. Fromkess are grandparents of an eight-pound boy, Bruce Robert, born on August 20, 1956, to Mr. and Mrs. Robert C. Pinkerton of Honolulu.

Addressed . . .

. . . doctors' wives

Dr. William Stevens spoke before the Woman's Auxiliary to the Honolulu County Medical Society on "Nine Out of Ten."

. . . churchgoers

Dr. Roy Ohtani talked on "The How and Why of Meditation" before the congregation of the Nuuanu Congregational Church.

. . . linguists

Dr. Lionel Ferrari of St. Francis Hospital addressed the Italian conversation group of the International Institute, and **Dr. Walter E. Printzen** spoke before the Spanish language group.

. . . televiewers

Drs. Raymond de Hay, L. Clagett Beck, Richard K. C. Chang, Randal Nishijima, and **John M. Felix** discussed ulcer and cancer of the stomach in a panel presentation over television station KONA in August.

Drs. Robert M. Chung, Charlotte M. Florine, Dorothy S. Natsui, and **K. S. Tom** discussed "Change of Life" over KONA in September.

Travelers . . .

. . . to the mainland

Dr. Clagett Beck attended the meetings of the Southern Medical Association in Washington, D. C., the American Geriatrics Society in New York, and the American College of Physicians in Oklahoma City.

Dr. Philip M. Corboy attended the American Legion Memorial Highway Committee in Indianapolis and discussed plans for a new memorial highway planned by the Legion for Honolulu.

. . . down under

Dr. Frank H. Hatlelid will be ship surgeon on S.S. Mariposa on her first return trip to Australia and New Zealand on November 2, 1956.

. . . from Japan and Korea

Dr. Herbert E. Bowles returned from a month's service at Kunsan Provincial Hospital in Korea. This trip was sponsored jointly by the American Friends Society Committee of Philadelphia and the Friends Society Council of London.

Diathermy Equipment For Sale
Telephone 74-4237

Doctor has vacated office in the King Kalakaua Building for larger office but still has a two-year lease on King Kalakaua Building. Will sublet at reduced rent. For further information call 99-0933 or 99-6402.

A.M.E.F.

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1. It will reduce your tax liability for this year—which is higher than you think!

2. If you're obligated to a fellow physician for his professional services, make a donation to the A.M.E.F. in his name. He'll appreciate it!

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*TRADEMARK

INTER-ISLAND NURSES' BULLETIN

Official Publication of the Nurses' Association, Territory of Hawaii

MRS. OLIVE C. PRIDGEN, *Executive Secretary,* Honolulu

BULLETIN COMMITTEE

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IRENE ZANE, Honolulu
HAZEL FLAGG, Hawaii
MARGARET WATANABE, Maui
JOSEPHINE DUVAUCHELLE, Kauai

PRESIDENT'S MESSAGE

I welcome this opportunity to send greetings to all of the nurses of Hawaii and especially to the members of the Territorial Nurses' Association. As your newly elected President, I am very mindful of the responsibility you have given me and shall do my utmost to justify your confidence.

The loss of Sister Mary Albert's leadership, due to her transfer to the mainland, will be keenly felt by us all. Her acute awareness of our problems, her unerring sense of the direction in which we should move, and her ability to get the job done are qualities which are difficult to duplicate. We shall all have to make additional efforts to compensate for her absence.

Strong, progressive professional organizations do not stem from the efforts of a few elected officers, but depend essentially upon an interested, willing, and active membership. While numbers alone will not determine the effectiveness of our organization, nevertheless we need representatives of a broad cross-section of those practicing nursing; hence, all active nurses are urged to become participating, contributing members of our group.

Professional nursing should concern itself with the interests and welfare of individual nurses. However, it has a broader obligation to provide the best nursing care to all the people of our community by improving nursing practice. Both goals seem to have been kept well in mind, for out of the recent convention came many suggestions for areas needing study and improvement. Undoubtedly, as all section reports are assembled and reviewed, we shall be aware of many more such needs. The Board of Directors will soon have its first meeting, at which time we should be able to sort out those problems needing first attention, and plan a course of action for others.

You, the membership, determine the kind of program the Association undertakes. All of the officers know we have a tremendous obligation to carry out your wishes, but please remember—we must know what you want and we need your help to do it!

LYNNE WIGEN, R.N., *President*
Nurses' Association, T. H.

RESOLUTIONS
ADOPTED AT THE
25TH ANNUAL CONVENTION
OF THE
NURSES' ASSOCIATION, TERRITORY OF HAWAII, INC.

September 22, 1956

Territorial Hospital

WHEREAS, We feel that adequate care of the mentally ill is a responsibility of all citizens; and

WHEREAS, The American Psychiatric Association has recommended certain ratios of nursing personnel required to care for the needs of patients and has established minimum standards of nursing care; and

WHEREAS, According to these standards, there exists a definite shortage of nursing personnel to give adequate and safe nursing care to mentally ill patients at the Territorial Hospital; and

WHEREAS, There are insufficient personnel to provide for coverage for days off, vacation, sick leave and holidays, resulting in the frequent neces-

sity of requiring the nursing staff to work sixteen-hour duty in order to staff the wards; therefore be it

RESOLVED, That the Nurses' Association, Territory of Hawaii, Inc., give its full support to the Territorial Hospital in its request for additional nursing personnel; and be it further

RESOLVED, That evidence of this support be given the widest possible circulation through any and all media which the Nurses' Association may have available.

Public Health Nurses

WHEREAS, The Territorial Department of Health has repeatedly asked the Territorial Legislature for funds to increase the number of public health nurses commensurate with approved programs with very little success; and

WHEREAS, It is estimated that one additional supervisor, fourteen additional staff public health nurses and one nursing clerk are necessary to accomplish adequate public health nursing services on all Islands; therefore be it

RESOLVED, That the Public Health Nursing Section of the Nurses' Association, Territory of Hawaii recommends and urges that the Territorial Legislature be again informed of this need, and that we go on record as urging the appropriation of additional positions and funds as needed to expand the public health nursing services as recommended.

Civil Defense

WHEREAS, We believe that an adequate and realistic civil defense program is of grave importance to all the people of Hawaii; therefore be it

RESOLVED, That the Nurses' Association, Territory of Hawaii, Inc., recommends that citizen groups representing government and private enterprise undertake and support a program of education regarding civil defense for the purpose of enlisting the greatest understanding, cooperation and participation of the community at large.

Traineeship for Nurses—Public Law 911

WHEREAS, There exists an extreme shortage of nurses prepared for higher positions in all fields of nursing; therefore be it

RESOLVED, That the Nurses' Association, Territory of Hawaii give wide publicity to the traineeships available through Public Law 911; and be it further

RESOLVED, That employers of nurses be urged to encourage interested and qualified applicants by granting leaves of absence whenever possible for such study.

Sister Mary Albert

WHEREAS, Our beloved President, Sister Mary Albert, is completing her term of office; and

WHEREAS, We all have had the opportunity to benefit from her inspired leadership and wise counsel; and

WHEREAS, Her rare ability to enlist people in activities which they felt were beyond their talents or time schedule is well known; and

WHEREAS, We shall soon be left without her guidance because of her imminent transfer to St. Elizabeth's Hospital, Utica, New York as director of nursing; therefore be it

RESOLVED, That the members of the Nurses' Association, Territory of Hawaii, assembled for their 25th Annual Convention, express their deep appreciation for devotion to the service of their needs and interests; and be it

RESOLVED, That the Nurses' Association express its regret that such an outstanding person will no longer participate in its activities; and be it further

RESOLVED, That a copy of this resolution be published in the Inter-Island Nurses' Bulletin and the newspapers and a copy be sent to Mother Jolenta, Superior General of the Sisters of the Third Order of St. Francis in Syracuse, New York, assuring the Order of the high regard in which Sister Mary Albert is held by this Association.

Elizabeth Middleton

WHEREAS, Elizabeth Middleton, who is one of the outstanding members of the Nurses' Association, Territory of Hawaii, Inc. is absent at this 25th Annual Convention because of illness; therefore be it

RESOLVED, That the members of the House of Delegates wish her to know that her presence has been greatly missed, and that they all wish her a speedy recovery.

I WAS IN STOCKHOLM FOR THE ICN

MABEL GORDON, R.N.

Membership in the national association entitles you in turn to be a member of the International Congress of Nurses.

Every nurse should feel herself personally responsible for the happiness and welfare of all nurses from other countries. The ICN is a fact-finding coordinating body in a position to spread information concerning nursing progress to all countries and also equipped to enter research for the improvement of nursing. Founder of the ICN was Mrs. Bedford Fenwick and the initial meeting of the Council was in 1899.

Mrs. Fenwick at that time had said, "The work in which nurses are engaged in other countries is precisely the same as is our own. The principles of organization are the same in every country, and the need for nursing progress is the same for every country. It depends upon nurses individually and collectively to make utmost possible usefulness of their profession. To secure these results two things are essential: that there should be a recognized system of education, and control by nurses over the nursing profession."

The above was requoted in Stockholm, Sweden, in 1949 at the 50th anniversary of the ICN by the first speaker, Miss Daisy Bridges of London, executive secretary, ICN, who added "that these words are as true today as they were 50 years ago and that we should be proud to be members of the oldest International Association of Professional Women." Other speakers were the general director and director of the Medical Board of Sweden, also president of Swedish Medical Association, president of Swedish Business and Professional Women's Association.

To greet the group of 4,000 delegates representing 35 countries, with ease and grace, was the acting president of the Swedish Nurses' Association, Miss Karen Elfersen, who spoke in four languages. Also there to welcome us was Miss Gerda Hajer, president of ICN, and Princess Sybilla representing the Crown Princess Louise of Sweden. Response to roll call was given by each country represented. There were 500 from the United States and its territories. New member countries admitted were Haiti, Italy, Southern Rhodes, Turkey, and Korea.

We were housed in school classrooms, hospital wards, homes, and a few hotels. The hospitality, generosity, and organization could never be excelled anywhere. I could write for days of the many interesting events and adventures that took place during my three and one-half months' jaunt. There were two other nurses who left Honolulu for the ICN in Sweden. I first met them in a hotel in London where I stayed.

I left home in 1949, in the latter part of May, via Los Angeles and Mexico City, to visit friends, and then on to Dallas, Washington, D. C., and New York where I left with 75 other American nurses on the S.S. "Washington," a former troop ship. I met more nurses upon our arrival in London. In seven buses we toured England, Scotland, sailed to Bergen, Norway, and toured by buses through part of the fjords and the remaining journey by train arriving in Stockholm early Sunday. While in Oslo, several of us met our relatives and stayed there for one night. In Stockholm I stayed at the New South Hospital, which is supposed to be larger than our Tripler Army Hospital.

One day of the convention was taken to make long train tours to visit other cities, their hospitals, and points of interest. For each train load, there were approximately 500 to 700 nurses. The city fathers entertained, wined, and dined us after touring, and even saw us off at the late train to return to Stockholm and our sleeping quarters.

Convention over, there were three buses of Americans who went to Rome via Denmark, Switzerland, Germany, Italy, and back to Paris, France, to see the familiar places where I had worked during the early part of the European war after leaving China in 1930.

Second Meeting of ICN

I left here the latter part of May, 1953, and went to the golden jubilee of my nursing school in Tacoma, Washington, and on to San Francisco, Los Angeles, Mexico City, Guatemala, and Panama City. In the latter city I met nurses on their way to ICN, some of whom I had met at the previous meeting. From here we visited Lima, Peru, where I met Mrs. Virginia Ahrendt of Honolulu and then flew over the heights of the famous Andes and over Lake Titikaka to the Chicago of South America, Sao Paulo, to beautiful Rio de Janeiro, Brazil, and up to our convention hotel in the cold mountains.

The 1953 meeting of the ICN was in Petropolis, 40 miles out from Rio de Janeiro. The hotel there had been a gambling resort but since gambling had been banned by the state, the government used the hotel for conventions, as it had all the facilities for such. There we all stayed in the same hotel, 1,400 of us, and it gave us a good opportunity to visit and meet more nurses from the many countries represented.

The person who opened the hotel door for me was Mrs. Gloria Foster of Maui, a long time friend.

After the convention, I flew down to Buenos Aires, Argentina, and later back up to the Atlantic coast via Dutch, French, and British Guiana, and made stops at many of the Caribbean Islands. On a sight-seeing tour to Puerto Rico I saw Gloria's name on a visitor's book.

After a few weeks in fabulous Florida, I made further stops at New Orleans, Dallas, Los Angeles, and on to San Francisco to attend the National Hospital Association and the National Anesthetists' Association conventions. There in a bathroom mirror I spied Betsy Barker, anesthetist at Hilo Memorial Hospital.

THE 1957 ROBERTS FELLOWSHIP

Applications for the 1957 Mary M. Roberts Fellowship in Journalism are now being accepted by the American Journal of Nursing Company's Fellowship Committee.

This is the eight in the series of Roberts Fellowships that have been made available to graduate nurses. The recipient of the fellowship will be granted a sum of $3,000, over and above tuition fees, to help defray the expense of one academic year of study in journalism at a recognized college or university.

The fellowship was established in 1950 by the American Journal of Nursing Company as a special tribute to its distinguished editor emeritus,

Mary M. Roberts, who has devoted so much of her lifetime to writing for and about the nursing profession. The basic purpose of the fellowship is to permit professional nurses to acquire and develop the special writing skills they need to write about nursing and to effectively interpret its special problems for the benefit of other professional groups and the general public through the medium of professional and lay publications.

Under the terms of the Roberts Fellowship, the recipient may select the school in which he or she wishes to study, but this choice must be approved by the Fellowship Committee, and at least 75 percent of the courses which are undertaken must be concerned directly with writing, journalism or allied fields of communication.

Competition for the fellowship is open to any professional nurse who meets the following eligibility requirements:

1. Membership in the American Nurses' Association or the National League for Nursing or both.
2. Eligibility for admission to a recognized college or university.
3. Intention to continue in nursing.
4. Interest in nursing and demonstrated ability in at least one area of nursing.
5. Citizenship—or declaration of intent to become a citizen—in the United States of America.
6. Freedom to study during the school year beginning in the fall of the year the award is made.

Each competitor must prepare and submit an original manuscript of not more than 3,000 words to the Fellowship Committee. The subject must be significant to nursing, the manuscript must be specially prepared for this competition, and the readers to whom it is directed must be specified. A special panel of judges will select the winner on the basis of the manuscript's excellence, the author's general professional qualifications, and the author's interest and writing facility as it is evidenced in the manuscript.

Application forms and complete details of the competition may be obtained from the Roberts Fellowship Committee, American Journal of Nursing Company, 2 Park Avenue, New York 16, New York.

Final date for submitting the finished manuscript and credentials is February 1, 1957.

MATERIA MEDICA

MARGARET THOMAS

Two widely used adrenocortical hormones in the field of medicine today are cortisone acetate and hydrocortisone. Cortisone is often referred to as Kendall's "Compound E" while hydrocortisone is known as Kendall's "Compound F."

Although the two hormones' action and uses are essentially the same, they do differ in chemical structure. Hydrocortisone is more potent than cortisone, being qualitatively as effective as cortisone in smaller doses. With these smaller doses, undesired side effects have been reported to be less frequent and less marked.

The official forms of cortisone are: Tablets 5 and 25 mg., Sterile Cortisone Acetate Suspension 25 mg./cc., and Cortisone Acetate Ophthalmic Suspension 0.5% and 2.5%. The more common trade names are Cortisone Acetate Tablets by Upjohn, Cortone by Sharp and Dohme, and Cortogen Acetate Tablets by Schering.

In general the oral dose is about the same as the parenteral dose, with the initial dosage of 100 mg. per day, in most conditions, until adequate control is achieved. The suspension is given intramuscularly.

The official forms of hydrocortisone are Tablets 5, 10, and 20 mg., Hydrocortisone Acetate Ointment and Sterile Hydrocortisone Acetate Suspension 25 mg./cc. The common trade names are Cortef by Upjohn, Cortril by Pfizer and Hydrocortone by Sharp and Dohme.

Dosage does not depend so much on the specific diagnosis as on the acuteness, prognosis and expected duration of the disorder. The dosage of hydrocortisone may generally be calculated as approximately ⅔ that of cortisone acetate.

Hydrocortisone and cortisone are now found in ampuls of 20 cc. containing 100 mg. for intravenous infusion only. This is an emergency preparation, dramatically effective and even life saving in cases involving surgical shock, transfusion reactions, severe drug reactions and acute allergic emergencies.

NEVADA NURSES TAKE NOTE

Nevada State Nurses' Association has prepared a golden anniversary brochure in celebration of their 50th anniversary. This brochure is a beautifully illustrated history of Nevada State Nurses' Association.

They are available at NSNA headquarters office 303 Merchants National Building, Omaha, Nebraska, for $1.00 a copy.

LEGISLATIVE PROGRAM

A special meeting of the available interested members of Nurses' Association, Territory of Hawaii, Inc. and Board for the Licensing of Nurses to make recommendations regarding NATH's legislative program for the year was opened by Sister Mary Albert at 8:20 a.m. on August 29, 1956 at the Mabel Smyth Building.

Problems presented were:

1. There are no board member qualifications written into the present law.

2. There is a request for a representative from the Practical Nurses' Association to serve on the Board for Licensing.

3. That it is too late at this time to initiate legislative action which would be ready in time for the 1957 Legislature.

Discussions that followed:

1. The possibility of a practical nurse committee being appointed in an advisory capacity to the Board for Licensing.

2. That no action be taken at this time regarding practical nurse membership on the Board.

MOTION: It was moved that the Board for Licensing of Nurses and members of NATH work together on a complete redraft of the present law and present this to the House of Delegates of NATH at the 1957 Convention for approval, then be ready for the 1959 Legislature.

The motion was carried.

MOTION: It was moved that NATH recommend to the Board for Licensing that the Practical Nurses' Association be invited to set up a committee to act in an advisory capacity to Board for Licensing.

The motion was carried.

MOTION: It was moved that the qualifications of Board members be written into the law.

The motion was carried.

MOTION: It was moved that we accept the ANA definition of the professional and practical nurse and include in our law.

The motion was carried.

MOTION: It was moved that a charge be made for examination retakes.

The motion was carried.

It was agreed that this committee meet again to discuss further tentative plans for 1959 legislation after the above recommendations have been carried back to the NATH membership and have had more consideration by the Board for Licensing.

Meeting adjourned at 9:30 a.m.

SISTER M. LAURINE, *Secretary*

CONGRESS VOTES EDUCATION AID FOR NURSES

The culmination of years of work by the American Nurses' Association and state nurses associations came on July 23 when Congress passed legislation providing for funds to aid nursing education.

Department of Health, Education, and Welfare
Public Health Service
Division of Nursing Resources

Basic Information
On
Professional Nurse Traineeship Program

The Health Amendments Act of 1956, passed by the Congress on July 23 and signed by the President as Public Law 911 on August 2, establishes a yearly program for each of three years, to provide graduate or specialized training for qualified nurses. The Public Health Service will administer the program.

Provision for graduate nurse training is contained in two sections of the Act. Title I authorizes $1 million for the period July 1, 1956 to June 30, 1957, for training in public health for physicians, nurses, engineers and other public health personnel. The emphasis in Title I, as far as nursing is concerned, is on preparation for staff positions in public health nursing. For information on traineeships for this purpose write to the Chief, Division of General Health Services, Bureau of State Services, Department of Health, Education, and Welfare, Washington 25, D. C.

Title II authorizes $2 million for the 1956-57 year for advanced preparation of nurses for administrative, supervisory and teaching positions in all fields of nursing. Detailed information on this program is as follows:

Q. What is the purpose of the Professional Nurse Traineeship Program?

A. The purpose of this program is to increase the number of professional nurses trained for positions as (a) teachers in schools of nursing (basic and advanced professional schools: practical nurse schools); (b) supervisors of nursing services in hospitals, nursing homes, public health agencies and industries; (c) administrators of nursing education programs; and of nursing services in hospitals, public health agencies, nursing homes, and industries.

Q. Who may apply for a traineeship?

A. Graduates of State approved schools of nursing are eligible. Candidates must be citizens of the United States or have filed a Declaration of Intent.

Q. Where should a nurse apply for a traineeship?

A. Application should be made directly to the training institution, *not* to the Public Health Service.

Q. How will candidates be selected?

A. The training institution will follow established admission policies in selecting candidates for these traineeships.

Q. Can a student enter the training institution at any time?

A. Yes. Traineeships may be used for students entering their specified programs in the fall term or any succeeding term. They may enter programs of study at the beginning, or at any stage which they previously have achieved.

Q. Can a traineeship be used for attendance at summer session?

A. Yes, if attendance at a summer session will enable a student to complete a program, or is part of a continuous program.

Q. Are students now enrolled part-time eligible for traineeships?

A. Yes. Conversion of part-time to full-time student by the use of traineeships should have high priority.

Q. Can a student receive a traineeship for more than one year?

A. Yes, although preference should be given students who, by having a trainceship, can complete a program in one year.

Q. What does a traineeship cover?

A. Traineeships include tuition and required fees, as listed in the institution bulletin, a stipend for living expenses, and some travel allowance. The annual (12 months') amounts for traineeship stipends (to be prorated and paid on the basis of one-twelfth for each month of training) are as follows: Pre-bachelor's—$2,400; Post-bachelor's—$3,000; Post-master's—$3,600. Cost of books and supplies are not included. Cost of travel of the trainee from his present location to the training institution will be allowed at six cents a mile as computed by standard mileage charts. Cost of travel from the training institution to old or new address after completion of study is not covered, nor is cost of travel of dependents, or shipping charges of personal effects or household goods.

Q. Does the travel allowance cover travel to and from centers of field practice?

A. Yes, if the center where such practice is given is outside the city in which the training institution is located.

Q. Is there allowance for dependents?

A. Yes. $360 a year is allowed for each legal dependent. This amount is to be prorated on the basis of the length of the traineeship.

Professional Nurse Training Program
Training Institutions

Miss Florence A. Hixson
Dean, School of Nursing
University of Alabama
University, Alabama

Mrs. Kathryn J. Nelson
Dean, Department of Nursing
College of Medical Evangelists
Loma Linda, California

Miss June T. Bailey
Dean, School of Nursing
University of California
Berkeley, California

Mrs. Lulu W. Hassenplug
Dean, School of Nursing
Unversity of California
Los Angeles,California

Mrs. Henrietta Adams Loughran
Dean, School of Nursing
University of Colorado
Boulder, Colorado

Miss Elizabeth S. Bixler
Dean, School of Nursing
Yale University
New Haven, Connecticut

Sister M. Olivia Gowan
Dean, School of Nursing
Catholic University
Washington, D. C.

Miss Vivian N. Duxbary
Dean, School of Nursing
Florida State University
Tallahassee, Florida

Miss Ada Fort
Dean, School of Nursing
Emory University
Atlanta, Georgia

Miss C. Louise Grant
Dean, School of Nursing
University of Georgia
Athens, Georgia

Mrs. Florence Finette
Chairman, Nursing Department
DePaul University
Chicago, Illinois

Miss Frances C. Thielbar
Chairman, Nursing Department
University of Chicago
Chicago, Illinois

Miss Dotaline E. Allen
Director, School of Education
Indiana University
Bloomington, Indiana

Mrs. Myrtle K. Aydelot
Dean, School of Nursing
State University of Iowa
Iowa City, Iowa

Sister Henrietta
Director, School of Nursing
Louisiana State University
New Orleans, Louisiana

Miss Florence M. Gipe
Dean, School of Nursing
University of Maryland
Baltimore, Maryland

Miss Marie Farrell
Acting Dean, School of Nursing
Boston University
Boston, Massachusetts

Miss Evangeline H. Morris
Director, Department of Nursing
Simmons College
Boston, Massachusetts

Miss Mildred Sanders
Director, Department of Nursing
Mercy College
Detroit, Michigan

Miss Ella S. McNeil
Professor of Public Health Nursing
School of Public Health
University of Michigan
Ann Arbor, Michigan

Miss Katharine E. Faville
Dean, School of Nursing
Wayne University
Detroit, Michigan

Miss Katharine J. Densford
Director, School of Nursing Education
University of Minnesota
Minneapolis, Minnesota

Miss Marion Murphy
Director of Public Health Nursing
School of Public Health
University of Minnesota
Minneapolis, Minnesota

Sister M. Susanne
Dean, School of Nursing
St. Louis University
St. Louis, Missouri

Miss Louise Knapp
Director, School of Nursing
Washington University
St. Louis, Missouri

Mrs. Margaret Shay
Dean, Department of Nursing
Adelphia College
Garden City, New York

Mrs. R. Louise McManus
Director, Division of Nursing Education
Teachers College
Columbia University
New York City, New York

Miss Martha E. Rogers
Chairman, School of Education
New York University
New York City, New York

Mrs. Mary E. Reap
Chairman, Department of Nursing
St. John's University
Brooklyn, New York

Miss Jean Barrett
Chairman, Department of Nursing
Syracuse University
Syracuse, New York

Mrs. Anne W. Sengbusch
Dean, School of Nursing
University of Buffalo
Buffalo, New York

Miss Esther M. Thompson
Chairman, Division of Nursing Education
University of Rochester
Rochester, New York

Miss Thelma Ingles
Director, Department of Nursing Education
Duke University
Durham, North Carolina

Miss Elizabeth L. Kemble
Director, School of Nursing
University of North Carolina
Chapel Hill, North Carolina

Miss Ruth W. Hay
Director, School of Public Health
University of North Carolina
Chapel Hill, North Carolina

Miss Mildred E. Newton
Director, School of Nursing
Ohio State University
Columbus, Ohio

Miss Elizabeth K. Porter
Dean, Frances Payne Bolton School of Nursing
Western Reserve University
Cleveland, Ohio

Miss Henrietta Doltz
Director, School of Nursing
University of Oregon Medical School
Portland, Oregon

Miss Theresa I. Lynch
Director, School of Nursing
University of Pennsylvania
Philadelphia, Pennsylvania

Mrs. Ruth P. Kuehn
Dean, School of Nursing
University of Pittsburgh
Pittsburgh, Pennsylvania

Miss Helen Gilkey
Director, Department of Nursing
South Dakota State College
Brookings, South Dakota

Miss Julia Hereford
Dean, School of Nursing
Vanderbilt University
Nashville, Tennessee

Miss Marjorie Bartholf
Dean, School of Nursing
University of Texas
Galveston, Texas

Mrs. Mary S. Tschudin
Dean, School of Nursing
University of Washington
Seattle, Washington

Mr. Fred R. Hanson
Dean, Department of Nursing
Walla Walla College
College Place, Washington

Sister M. Thomas
Dean, School of Nursing
Marquette University
Milwaukee, Wisconsin

Miss Margery MacLachlan
Director, School of Nursing
University of Wisconsin
Madison, Wisconsin

*Schools of Public Health**

Dr. C. E. Smith
Dean, University of California School of Public Health
Berkeley 4, California

Dr. Ray E. Trussell
Director, School of Public Health and Administrative Medicine
Columbia University
New York 32, New York

Dr. John C. Snyder
Dean, School of Public Health
Harvard University
Boston 15, Massachusetts

Dr. E. L. Stebbins
Director, School of Hygiene and Public Health
Johns Hopkins University
Baltimore 5, Maryland

Dr. Thomas Parran
Dean, Graduate School of Public Health
University of Pittsburgh
Pittsburgh 13, Pennsylvania

Dr. Ira V. Hiscock
Chairman, Department of Public Health
Yale University
New Haven, Connecticut

Dr. E. Harold Hinman
Dean, School of Medicine—School of Tropical Medicine
University of Puerto Rico
San Juan, Puerto Rico

* Schools of Public Health of the Universities of Michigan, Minnesota and North Carolina are included in the basic list.

BYLAWS

of

Nurses' Association, Territory of Hawaii, Inc.

(as Revised September 20, 1956)

ARTICLE I—Title and Functions

Section 1. The name of this association shall be the Nurses' Association, Territory of Hawaii, Inc.

Section 2. The functions of the Nurses' Association, Territory of Hawaii, Inc. shall include the following:

1. To assist with the definition of the functions of nurses and to promote standards of professional nurse practice.
2. To assist with the definition of the qualifications for the practitioners of nursing including those in the various nursing specialties.
3. To promote legislation and to speak for nurses in regard to legislative action concerning general health and welfare programs.
4. To promote and assist with periodic surveys of territorial nursing resources.
5. To promote and protect the economic and general welfare of nurses.
6. To provide professional counseling service to individual nurses, and to their employers in regard to employment opportunities and available personnel.
7. To cooperate with the Hawaii League for Nursing in activities which concern both organizations.
8. To represent nurses and serve as their territorial spokesman with allied professional and government groups and with the public.

ARTICLE II—District Associations

Section 1. District nurses' associations which have been or hereafter may be organized, whose constitution and bylaws are in harmony with the bylaws of this association and have been approved by majority vote of the board of directors of the association, shall be recognized as constituent associations of the Nurses' Association, Territory of Hawaii, Inc.

Section 2. The boundaries of the district nurses' associations shall be clearly defined and recorded by the board of directors of this association. The boundaries may be changed by two-thirds vote of the board of directors of this association provided such change has been approved by each district involved.

Section 3. Any district nurses' association which fails to comply with the requirements of these bylaws or for other causes deemed sufficient, may be disqualified as a constituent association of the Nurses' Association, Territory of Hawaii by two-thirds vote of the board of directors provided due notice has been given to the district association three months before the vote is taken.

Section 4. A district nurses' association which has been disqualified may be reinstated by two-thirds vote of the board of directors of this association.

ARTICLE III—Membership

Section 1. The membership of the Nurses' Association, Territory of Hawaii, Inc. shall consist of active and associate membership of the constituent district associations.

The presentation to this association of a classified list of active and associate members in good standing in the district nurses' associations, signed by the secretary of those associations together with the annual dues of such members, shall establish such members of the district nurses' associations as members of this association.

Members of district nurses' associations shall be nurses who are graduates of state accredited schools of nursing offering programs of not less than two years of instruction and clinical practice in hospitals and in other community agencies, each of whom has been granted a license to practice as a registered nurse in at least one state, which license has not been revoked in any state for professional misconduct.

Section 2. The active members of this association shall be the active members of the constituent district nurses' associations and shall have all privileges of membership. Only active members shall have the privileges of voting and serving as delegates or alternates at conventions and special meetings of this association and of the American Nurses' Association.

(All) Members will have representation in the International Council.

Only active members shall be eligible to hold office and to serve as chairman of standing committees of this association.

Section 3. The associate members of this association shall be the associate members of the constituent district nurses' associations provided that such membership shall not be denied to any eligible nurse unless such nurse anticipates employment for more than thirty (30) days during the current calendar year. No member or applicant for membership shall be required to become an associate member if active membership is preferred. The associate member shall be an associate member of the American Nurses' Association.

Section 4. Honorary recognition may be conferred by a unanimous vote of any annual convention on persons other than registered professional nurses who have rendered distinguished service or valuable assistance to the nursing profession upon recommendation of the board of directors. Honorary recognition shall not be conferred on more than two persons at any annual convention.

Honorary recognition does not confer the privilege of voting nor require payment of dues. These persons may attend the meetings of the assembly only on invitation. They will receive the official publications and bulletin of the Nurses' Association, Territory of Hawaii, Inc.

Section 5. A member who changes her residence from the state in which she is a member of the state nurses' association through which she is a member of the American Nurses' Association shall be eligible to membership in the Nurses' Association, Territory of Hawaii, Inc. for the remainder of the fiscal year without further payment of dues provided she meets the requirements for membership in this association and the request for transfer of membership is accepted by this association. Such request shall be sent to the secretary of this asso-

ciation by the secretary of the state nurses' association issuing the transfer.

A member of this association who moves out of this territory should apply to the secretary of her district association for transfer of her membership to the state nurses' association of the state in which she will reside.

Section 6. Nurses shall become members of the district in which they reside.

ARTICLE IV—Dues

Section 1. (a) The annual dues to the Nurses' Association, Territory of Hawaii, Inc. shall be eighteen dollars ($18.00) per capita for active members, payable on or before February 10 by the constituent district associations which includes five dollars ($5.00) per capita dues to the American Nurses' Association.

(b) The annual dues for associate members of the Nurses' Association, Territory of Hawaii, Inc. shall be two dollars and seventy-five cents ($2.75) per capita payable on or before February 10 by the constituent district associations, which includes one dollar and twenty-five cents ($1.25) per capita dues to the American Nurses' Association.

Dues for associate members who become active members during any fiscal year and who have paid dues as associate members for that year, shall be fifteen dollars and twenty-five cents ($15.25) in addition to the two dollars and seventy-five cents ($2.75) previously paid. From the amount fifteen dollars and twenty-five cents ($15.25) paid in, three dollars and seventy-five cents ($3.75) will be sent to American Nurses' Association.

(c) The dues for nurses who graduate and are licensed to practice professional nursing after July 1 of any year and become active members of the Nurses' Association, Territory of Hawaii, Inc. shall be eight dollars and fifty cents ($8.50) per capita, for that same year, and payable by the constituent district nurses' association which includes two dollars and fifty cents ($2.50) per capita dues to the American Nurses' Association.

Section 2. Dues received by the district nurses' associations after the 10th of February shall be paid to this association monthly during the remainder of the fiscal year.

Section 3. The district nurses' associations which have not paid dues for any members of this association by March 15 shall be notified by the treasurer and those who have not paid dues by April 15 shall be disqualified as constituent district associations of the Nurses' Association, Territory of Hawaii, Inc.

Section 4. Not later than March 15 the treasurer of this association shall pay to the American Nurses' Association five dollars ($5.00) per capita for the active membership and one dollar and twenty-five cents ($1.25) per capita for the associate membership of the Nurses' Association, Territory of Hawaii, Inc. for the current calendar year.

Section 5. Dues received by this association after February 10 shall be paid to the American Nurses' Association monthly for the remainder of the year.

Section 6. All dues paid to the American Nurses' Association shall be accompanied by a classified list of the members for whom dues are paid.

ARTICLE V—Officers

Section 1. The officers of this association shall be a president, a first vice president, a second vice president, a secretary, a treasurer and six (6) directors.

Section 2. Officers shall be elected at annual conventions as hereinafter provided.

Section 3. Officers shall perform the duties usually performed by such officers and also such duties as are specified by these bylaws and designated by the board of directors of this association.

Section 4. Vacancies in office shall be filled as hereinafter provided.

Section 5. No officers shall be elected to the same office for more than two (2) successive terms.

Section 6. No person shall be elected to serve as an officer or director of the Nurses' Association, Territory of Hawaii, Inc. who, at the same time, would be serving as a section chairman.

ARTICLE VI—Duties of Officers

Section 1. The president shall preside at all meetings of this association and all meetings of the board of directors and be a member ex-officio of all committees except the Committee on Nominations. The president or her alternate shall serve as a representative of the association at meetings of the Advisory Council of the American Nurses' Association. In the even years the president shall serve as chairman of the Coordinating Council of the Nurses' Association, Territory of Hawaii, Inc. and the Hawaii League for Nursing. The president shall be empowered to appoint all standing and special committees, except Nomination Committee, of the association with the approval of the board of directors.

Section 2. The vice presidents in order of rank shall assume the duties of the president in her absence. In the event of a vacancy occurring in the office of the president, the first vice president shall assume the duties of the president until the next annual convention or until her successor is elected. In the event of a vacancy occurring in the office of the first vice president, the second vice president shall assume the duties of the first vice president until the next annual convention or until her successor is elected. The first vice president shall be a member ex-officio of the Committee on Constitution and Bylaws.

Section 3. The duties of the second vice president shall be the same as those of the first vice president and she shall serve as temporary parliamentarian in the absence of the first vice president. She shall be a member ex-officio of the Committee on Nursing Information and Membership.

Section 4. The secretary shall be responsible for the minutes of the meetings of this association, and the board of directors. She shall be the custodian of the seal of this corporation and the permanent files of same. She shall be a member ex-officio of the Committee on Nominations. She shall prepare and deliver to the annual convention of this association, a report on the accomplishments of this association during the preceding calendar year. She shall deliver to her successor within one month after her election to office all records and the seal of this association. She shall notify all officers, directors and committees of election or appointment; send notices of the time and place of all meetings; send to the secretary of the American Nurses' Association the names and addresses of all officers of the Nurses' Association, Territory of Hawaii, Inc. immediately after their election; and conduct the general correspondence of the association and the board of directors.

She shall keep a correct list of the names and addresses of all members of this association.

The executive secretary shall assume such duties in

connection with the work of the secretary as shall be designated by the board of directors.

Section 5. The treasurer shall receive and have charge of all funds of the association, deposit such funds in a bank designated by the board of directors and pay such bills only as shall have been approved by the president.

She shall report to the board of directors the financial standing of the association at each annual convention.

She shall keep an itemized account of all receipts and disbursements and give a written report at meetings of the board of directors and of the association.

She shall give bond subject to the approval of the board of directors for the faithful performance of her duties, and shall submit all books of account for audit as specified by the board of directors.

She shall pay dues to the American Nurses' Association and send notice to district associations as specified in Article IV of these bylaws.

The treasurer shall be a member of the Committee on Finance.

The retiring treasurer shall deliver to her successor within one (1) month after her election to office all money, vouchers, books and papers of the association in her custody with a supplementary report covering all transactions from the date of last audit to the date of surrendering her accounts to her successor.

The executive secretary shall assume such duties in connection with the work of the treasurer as shall be designated by the board of directors.

After the board approves attendance at any meeting called by the American Nurses' Association and for which that association will pay travel expenses but for which this association must pay living expenses, the treasurer may advance payment for plane fare and living expenses at the rate of $15 per day.

Section 6. All officers except the secretary and treasurer upon expiration of their term of office shall surrender all property of this association in their possession pertaining to their respective offices to the newly elected president.

Section 7. In addition to the duties of the officers set forth herein, the officers shall have such other duties as implied by their titles.

ARTICLE VII—Board of Directors

Section 1. The members of the board of directors of this association shall be eleven (11) composed of: the president, first vice president, second vice president, secretary, and treasurer, and six (6) directors, four (4) of whom shall be selected, one each from the respective districts, to serve as the official representative of that district, in addition to these the chairmen of organized sections of the Nurses' Association, Territory of Hawaii, Inc., shall be regular members of the board of directors.

Section 2. The regular meeting of the board of directors shall be held immediately preceding and immediately following each annual convention* at the place where the annual convention is held. The regular meetings of the board may also be held at such time and place as shall from time to time be determined by action of the board.

Section 3. Special meetings of the board of directors may be called by the president of this association upon seven (7) days notice to each member of the Board either personally or by mail or by telegraph and shall be called by the president in like manner or by like notice upon the written request of five (5) members of the board of directors. Special meetings shall be held at such time and such place as may be specified in the notice thereof.

Section 4. In the intervals between regular meetings of the board of directors, the president of the association may refer and submit by mail or telegraph to the members of the board of directors definite questions relating to the affairs of the association which, in the opinion of the president, require immediate action on the part of the board of directors. The result of such a referendum which requires a majority vote of the personnel of the board of directors shall control the action of the association, its board of directors, officers, sections.

Section 5. Officers of the Territorial Student Nurses' Association shall be eligible to attend meetings of the board of directors of this association in rotation, one officer attending each meeting but without vote.

ARTICLE VIII—Duties of the Board of Directors

Section 1. The board of directors shall:

(a) Transact the general business of the association in the interim between annual conventions.

(b) Establish major administrative policies governing the affairs of the association and devise and mature measures for the association's growth and development.

(c) Provide for the maintenance of territorial headquarters and for making such office the center of activities of the association, including such work of the officers and committees as may be deemed expedient; provide for the proper care of materials, equipment and funds of the association, for the payment of legitimate expenses and for the annual auditing of all books of account by our agent if agency agreement is in effect; otherwise audit shall be made by a certified public accounting firm.

(d) Report to the association assembled at each annual convention through the secretary of this association the business transacted by the board during the preceding year.

(e) Assume responsibility with regard to constituent district nurses' associations as specified in Article II of these bylaws.

(f) Appoint an executive secretary and other personnel, define their duties and fix their compensation.

(g) Create special committees as the need for them arises, dissolving said committees upon the accomplishment of their missions.

(h) Approve the appointment of all members to standing and special committees made by the president in accordance with these bylaws.

(i) Have power to fill any vacancies on the board of directors except a vacancy occurring in the office of the president or first vice president.

(j) Decide upon the exact date and place for holding the annual convention and provide for the payment for a place of meeting when necessary; decide upon the time and place for meetings of the advisory council; hold meetings of the board of directors as hereinbefore provided.

(k) Provide for the establishment and dissolution of sections in accordance with these bylaws.

(l) Verify referendum votes of the board of directors.

(m) Appoint the association's representatives on Board of Management of the Mabel Smyth Memorial Building Committee in the manner provided for by the agreement made on October 15, 1939 between the Nurses' Association, Territory of Ha-

* Except where government regulations or conditions incident upon war may render this impossible.

waii, Inc., the Hawaii Medical Association and The Queen's Hospital.

(n) Recommend to the Governor of the Territory the names of persons suitable for appointments to the Board for the Licensing of Nurses when vacancies on said board occur.

(o) Shall have the right and authority by unanimous vote to appeal to the membership of this association, when necessary, for supplemental finances to carry on the program of the association.

(p) Appoint an active member, in addition to the president, or her alternate, to represent this association at meetings of the Advisory Council of the American Nurses' Association.

(q) Have the power to employ legal counsel and such other paid personnel as may from time to time be needed at fees made known to the board of directors in advance of such employment.

Section 2. No individual member of the board of directors shall pledge any property of this association for security either for a personal or an association loan nor will members contact any liabilities in the name of the association without first having in their possession written permission from the treasurer of this association as approved by the board of directors.

Section 3. There shall be an executive committee, called the sub-NATH, of the board of directors composed of the president, the officers and board members located on the Island of Oahu, and one other island director to be selected in rotation. This committee shall have all the powers of the board of directors to transact business of an essential nature between board meetings. All transactions of this committee shall be verified at the next regularly scheduled meeting of the board of directors.

ARTICLE IX—Coordinating Council

Section 1. **Membership.** There shall be a Coordinating Council which shall be composed of all the officers and other members of the board of directors of Nurses' Association, Territory of Hawaii, Inc. and all of the officers and other members of the board of directors of the Hawaii League for Nursing.

Section 2. **Officers.** Starting with the president of the Nurses' Association, Territory of Hawaii, Inc., the president of that association and the president of the Hawaii League for Nursing shall serve alternately for one (1) year as chairman of the Coordinating Council.

Section 3. **Purpose and Functions.** The coordinating Council shall promote the coordination of those programs that are of common concern to the Hawaii League for Nursing and the Nurses' Association, Territory of Hawaii, Inc. To promote such coordination, the Coordinating Council shall:

(a) Serve as a forum for the discussion of different points of view for the purpose of reaching agreement when feasible;

(b) Plan together, serve as a clearing house for activities of common concern to both the Hawaii League for Nursing and the Nurses' Association, Territory of Hawaii, Inc., and agree on allocation of new major programs; and

(c) Consider priorities for and timing of interrelated activities of the Hawaii League for Nursing and the Nurses' Association, Territory of Hawaii, Inc.

The Coordinating Council shall also act as sponsors of and advisers to the state student nurses' council or organization.

Section 4. **Steering Committee.** There shall be a Steering Committee for the Coordinating Council which shall be authorized to make recommendations when, because of an emergency or other special situation, a recommendation must be made before the Coordinating Council can meet. The Steering Committee for the Coordinating Council shall be composed of the president and elected secretary of the Nurses' Association, Territory of Hawaii, Inc. and the president and elected secretary of the Hawaii League for Nursing.

Section 5. **Special Committees.** The Coordinating Council of the Nurses' Association, Territory of Hawaii, Inc. and the Hawaii League for Nursing shall have authority to appoint special committees, if necessary.

ARTICLE X—Standing Committees

Section 1. The following standing committees shall be appointed at or immediately after each annual convention to serve until the next annual convention or until their respective successors are appointed:

1. Committee on Finance
2. Committee on Program
3. Committee on Arrangements
4. Committee on Legislation
5. Committee on Constitution and Bylaws
6. Committee on Nominations
7. Committee on Membership
8. Committee on Nursing Information
9. Committee on Margaret Jones Memorial Fund

Section 2. Standing committees except the Committee on Nominations and the Executive Committee (Sub-NATH) may be composed of both active and associate members of the association and shall assume such duties as are specified in these bylaws and such other duties as may be assigned by the board of directors. Only active members shall be chairmen of standing committees.

Section 3. The Committee on Finance shall consist of at least five (5) members and not more than ten (10), one of whom shall be the chairman as appointed by the president with the approval of the board of directors. The treasurer of the Nurses' Association, Territory of Hawaii, Inc. shall be a member of said committee. This committee shall prepare a budget for the year, advise as to expenditure of funds and report the same to the board of directors at meetings of that body.

Section 4. The Committee on Program shall consist of at least three (3) members representing at least the three major fields of nursing. This committee shall prepare a program for all meetings of this association, subject to the approval of the board of directors. This committee shall act in an advisory capacity to Committee on Program of district nurses' associations throughout the year.

Section 5. The Committee on Arrangements shall consist of at least three (3) members. This committee shall work in conjunction with the Committee on Program, subject to the approval of the board of directors, and shall make local arrangements for the annual convention and perform such other duties as shall be designated by the board of directors.

Section 6. The Committee on Legislation shall consist of at least five (5) members. The membership of this committee shall be representative of all major branches of nursing and various geographic sections of the territory.

The duties of this committee shall be to:

Study the program and objectives of the association to determine the needs for territorial legislation.

Receive proposals for legislative action from other committees of the association.

Evaluate all proposed legislation relating to nursing

and the programs of the association in order to determine and recommend the goals and resources of the association.

Devise methods for effective legislative action.

Section 7. The Committee on Constitution and Bylaws shall consist of at least three (3) members. This committee shall receive all proposed amendments to the bylaws of this association. It shall be responsible for securing an opinion from the American Nurses' Association Committee on Constitution and Bylaws with regard to the same, and shall recommend proposed action thereon to the board of directors of this association. Such proposed amendments shall be submitted for action to the voting body at the annual convention of the association in accordance with the provisions for amendments in these bylaws. This committee shall review the constitution and bylaws of any district nurses' association wishing to become a constituent association of the Nurses' Association, Territory of Hawaii, Inc. The committee shall report its findings to the board of directors of this association, whose decision as to the acceptability of the district shall be final. This committee shall advise district nurses' associations concerning proposed amendments to their constitution and bylaws in order that these may be kept in harmony with the bylaws of this association and of the American Nurses' Association. The first vice president shall be a member ex-officio of this committee.

Section 8. The Committee on Membership shall consist of three (3) or more members representative of various geographic areas of the territory. This committee shall cooperate with the ANA Committee on Promotion of American Nurses' Association Membership, and shall devise ways and means of cooperation with the district nurses' associations in securing members and in methods of organization for making such membership effective. Such action shall be subject to the approval of the board of directors. The second vice president shall be a member ex-officio of this committee.

Section 9. The Committee on Nominations shall consist of not less than three (3) active members. Not more than one (1) member of this committee is to be a member of any one district nurses' association. Ninety (90) days prior to the annual meeting the Committee on Nominations shall send to the district nurses' associations the names of officers then serving, and those whose terms of office will expire at the next annual convention, and shall request from each district nurses' association a list of names of members qualified to fill vacancies in office and willing to serve if elected. These members should be representative of various fields of nursing service. Such lists shall be signed by the president or secretary of the respective district nurses' associations and shall be submitted by the district nurses' associations to the Committee on Nominations of this association sixty (60) days prior to the annual convention. From these lists the Committee on Nominations shall prepare a ticket consisting of at least two (2) nominees for each office to be filled. This ticket shall include representatives of major branches of nursing and various geographic sections of the territory. The secretary shall be a member ex-officio of this committee.

Nominations Committee is to be an elected committee.

Section 10. The Committee on Nursing Information shall be representative of the various nursing groups in the territory. It shall be the function of this committee to plan and promote the territorial nursing information program subject to the approval of the board of directors. The committee shall inform nurses about the activities of the professional nursing organizations so that they will support the organizations, benefit by their services and participate intelligently in their programs. Also, the committee shall promote better understanding of professional nursing by the public so that it will make discriminating use of professional nursing service and insist on sound preparation for nursing. The second vice president shall be a member ex-officio of this committee.

Section 11. The Committee on Margaret Jones Memorial Fund shall consist of at least three (3) members. The vice president shall be a member (ex-officio) of this committee. The chairman of this committee, as appointed by the president, should be a nurse who has previously served as a member of the committee. It shall be the functions of this committee to receive requests for loans or gifts and to act upon them in accordance with the policies established in the deed of trust. To recommend to the board of directors, when the need arises, that certain loans be written off the books as gifts. To meet with representatives of the Bishop Trust Company each year following the audit of the fund to evaluate the yearly performance of our investments.

Section 12. Hawaii Student Nurses' Association members may be eligible to attend committee meetings of this association.

ARTICLE XI—Sections

Section 1. (a) Sections may be established by a majority vote of the board of directors of this association.

(b) A section may be established for each of the following groups of professional nurses:

(1) Private duty nurses
(2) General duty nurses
(3) Public health nurses
(4) Institutional nursing service administrators
(5) Educational administrators, consultants, and teachers
(6) Industrial nurses
(7) Special groups

(c) Members of a branch group in the territory shall be eligible to apply for status as a section when they meet the following criteria:

(1) In the Nurses' Association, Territory of Hawaii, Inc. with a membership of less than 1500, if they number at least thirty-five (35); and
(2) If the members of the branch group desiring status as a section have functioned as a conference group within one of the established sections for a year; and provided the number of members of the section does not fall below the numerical criterion for establishment of the section (35).
(3) If they have demonstrated group interest; and
(4) If they have developed a program; and
(5) If the needs of such a group cannot be met in any existing section or by continuation as a conference group.

(d) Membership in the Special Groups Section of the Nurses' Association, Territory of Hawaii, Inc. shall be open only to those nurses who are not eligible for membership in any other section.

Section 2. Functions of sections may include the following:

(a) Define the qualifications for membership which are consistent with the general membership requirements of the Nurses' Association, Territory of Hawaii, Inc.

(b) Make rules for its government, provided these shall in no way conflict with the bylaws of the Nurses'

Association, Territory of Hawaii, Inc. and shall be approved by the board of directors.

(c) Define the functions, standards, and qualifications for practice within the occupational field, these to be developed for each special field by the practitioners within it.

(d) Initiate studies or experiments for the improvement of practice within the field in relation to the overall purpose of the Nurses' Association, Territory of Hawaii, Inc.

(e) Study the general welfare and economic needs of the members and develop desirable standards of employment.

(f) Promote the organization of subunits within the section in order that groups which have like interests shall have the opportunity of meeting to consider the economic security program separately from other groups in the same section whose economic interests might be somewhat different. The subunits shall have the privilege of reporting directly to the board of directors of the Nurses' Association, Territory of Hawaii, Inc.

(g) Represent the occupational interests in district, territorial, and national meetings.

(h) Develop relationships with allied professional groups for conferences or committee work related to the objectives of the Nurses' Association, Territory of Hawaii, Inc.

(i) Conduct programs of special interest to the members of the occupational group or participate with other sections that have similar interests.

(j) Organize conference groups on request for special interests within the section.

(k) Develop and actively promote a program for intergroup relations within the section.

(l) Plan a program of work and prepare an appropriate budget annually for presentation to the Nurses' Association, Territory of Hawaii, Inc. Finance Committee.

(m) Make pronouncements in its own name, provided they are not in opposition to the policies accepted by the House of Delegates and do not purport to represent the policies of the association as a whole.

(n) Interpret all policies accepted by the House of Delegates that affect the section and publish same in its own name.

(o) Keep open direct channels of communication between the Nurses' Association, Territory of Hawaii, Inc. and district sections, with information going simultaneously to the executive secretary of the Nurses' Association, Territory of Hawaii, Inc. and the presidents and the secretaries of the district nurses' associations.

Section 3. Officers of the section shall be chairman, vice chairman and a secretary. The officers shall be elected annually at the annual convention of this association. The newly elected secretary will forward immediately to the secretary of this association the names and addresses of all newly elected officers.

Section 4. A section may be dissolved by two-thirds vote of the board of directors upon the following conditions:

> Upon the recommendation of the section concerned, or upon agreement by the board of directors and the section that there is no reason for its continuance, or upon the section's failure to carry out its objective or to conform with the requirements or principles of this association.

Section 5. A section which has been dissolved by action of the board of directors of this association in which the section does not concur, may appeal to said board of directors for reconsideration, or may appeal to this Association at any annual convention. The decision of this Association shall be final.

Section 6. All members of a section in attendance at a section meeting are entitled to vote on all matters coming before the section.

Section 7. Sections may engage in fund-raising, provided however, that plans for fund-raising be submitted to and approved by the board of directors.

ARTICLE XII—Elections

Section 1. The president, the second vice president and the treasurer shall be elected at the annual conventions held in the even years; and the first vice president and the secretary shall be elected at the annual conventions held in the odd years.

The term of office of these officers shall commence at the adjournment of the annual convention at which they are elected and shall continue for two (2) years or until their successors are elected.

Section 2. At each annual convention two (2) directors shall be elected to serve for three (3) years or until their successors are elected.

Section 3. All elections shall be by secret written ballot. A ticket of at least two (2) candidates for each office shall be prepared and presented to the convention assembled by the Committee on Nominations. No name shall be presented to the convention unless the nominee has agreed to serve if elected.

Section 4. A plurality vote of those present, entitled to vote and voting, shall constitute an election.

Section 5. On the first day of the annual convention the president shall appoint a special committee of tellers who shall act also as inspectors of the election. There will be one teller from each district nurses' association. No nominee or candidate for any office shall be appointed a member of this committee.

Section 6. The secretary of this association shall furnish the tellers at least two (2) hours before the opening of the polls a complete list of delegates and alternates of district nurses' associations entitled to vote. The teller in charge of the list of delegates shall check the names of those voting.

Section 7. The teller in charge of the ballot box shall place her official mark upon the back of each ballot. The voters shall then place the ballot in the ballot box.

Section 8. Polls shall be open for such periods of time as specified by the board of directors and noted in the program of the annual convention.

Section 9. Additional nominations may be made from the floor of the convention with the consent of those being nominated.

ARTICLE XIII—Representation

Section 1. The voting body at all meetings of this association shall consist of the accredited delegates in attendance from the district nurses' associations.

Section 2. Each district nurses' association shall be entitled to one delegate for each ten (10) active members, or portion thereof, computed on the basis of membership thirty (30) days prior to the opening day of the annual convention of the Nurses' Association, Territory of Hawaii, Inc. Any district nurses' association having less than ten (10) active members shall be entitled to one delegate. (Care should be taken in the district associations to choose delegates from the various fields of nursing.)

Section 3. The secretary of each district nurses' association shall send a list of accredited delegates from that

association by the most expeditious means, to the secretary of the Nurses' Association, Territory of Hawaii, Inc., at least thirty (30) days before the opening of the convention. A list of alternates will also be submitted by each district nurses' association in conjunction with the list of accredited delegates.

Section 4. If all the accredited delegates from the district nurses' association are not in attendance at the convention, the president of the district nurses' association, or her empowered representative, may fill the vacancies from the list of alternates for that association. If the list of alternates is exhausted and vacancies remain, the president of the district association, or her empowered representative, shall be empowered to appoint as delegates other members of that association who are in attendance.

Section 5. All delegates shall present credentials at the time of registration.

Section 6. Each accredited delegate shall be permitted to cast not more than one (1) vote in any election or any matter coming before the convention. This provision applies also to alternates or members who are acting as delegates appointed to represent a district nurses' association.

Section 7. (a) The Nurses' Association, Territory of Hawaii, Inc. is entitled to representation at biennial conventions or special meetings of the American Nurses' Association on the basis of one (1) delegate for every two hundred (200) active members of each section or fraction thereof, such delegate or delegates to be elected in a manner to be determined by the section. Each section, through the Nurses' Association, Territory of Hawaii, Inc., shall certify the names and addresses of the delegate or delegates and their respective alternates elected for such section. The number of delegates to be computed on the number of active members of each section of the Nurses' Association, Territory of Hawaii, Inc. in good standing in the ANA on December 31 of the year preceding a biennial convention or special meeting. Each section of each district nurses' association shall be asked to submit to the secretary of the corresponding territorial section a list of nominees for delegates and alternates to the biennial convention or special meeting. The number of delegates to be nominated by each section of the district shall be determined on the basis of membership as stated above. If any district nurses' association has no sections, it may submit names from the various fields of nursing within the district on the basis of membership as stated above. If such a district has less than one hundred (100) members, it may submit the name of one (1) nominee for delegate.

(b) Since the Nurses' Association, Territory of Hawaii, Inc. is entitled to three (3) delegates-at-large to biennial conventions or special meetings of the American Nurses' Association, these delegates-at-large shall be selected by the NATH board of directors from names submitted by the districts.

Section 8. If a special meeting is held in the month of January or February, for the purpose of computing the number of delegates to which any section of the Nurses' Association, Territory of Hawaii, Inc. shall be entitled, the number of active members shall be deemed to be the active members in good standing as active members of the American Nurses' Association on November 1 of the year preceding a special meeting, as evidenced by dues paid to this association or postmarked by such time.

Section 9. The representatives of this association at meetings of the Advisory Council of the American Nurses' Association shall be two (2) active members of this association, one (1) of whom shall be the president of this association or her alternate.

ARTICLE XIV—Meetings

Section 1. This association shall hold an annual meeting known as the Annual Convention of the Nurses' Association, Territory of Hawaii, Inc. at such time and place as shall be determined by the board of directors.

Section 2. The order of business of each annual convention of this association shall be in accordance with the program adopted at the beginning of the convention and shall include:

a. Call to order
b. Invocation
c. Appointment of tellers
d. President's address
e. Roll call of delegates
f. Report of Program Committee
g. Reading of minutes
h. Reports of officers
i. Reports of sections
j. Reports of district nurses' associations
k. Reports of standing committees
l. Reports of special committees
m. Old business
n. New business
o. Election of officers
p. Adjournment

Section 3. Special meetings of this association may be called by the board of directors and shall be called by the president upon written request of a majority of the district associations.

Section 4. Notice of all meetings of this association shall be sent to the president and the secretary of each district association and to all members of this association prior to the meeting in question. Notices of the annual convention shall be mailed at least one (1) month before the first day of the convention and notices of special meetings shall be mailed at least ten (10) days before the first day of the meeting.

Section 5. Members of the Hawaii Student Nurses' Association may attend meetings of the Nurses' Association, Territory of Hawaii, Inc.

ARTICLE XV—Quorum

Section 1. Seven (7) members of the board of directors, one (1) of whom shall be the president or a vice president, and representatives from a majority of the constituent district nurses' associations, shall constitute a quorum for the transaction of business at any annual convention or special meeting of the Nurses' Association, Territory of Hawaii, Inc.

Section 2. Seven (7) members of the board of directors, one (1) of whom shall be the president or a vice president, shall constitute a quorum at any meeting of the board of directors.

Section 3. A majority of members of the Advisory Council shall constitute a quorum of the Council.

Section 4. A majority of members of any standing or special committee shall constitute a quorum.

ARTICLE XVI—Fiscal Year

The fiscal year for this association shall be the calendar year.

ARTICLE XVII—Parliamentary Authority

The rules contained in *Robert's Rules of Order Revised* shall govern all meetings of the board of directors, committees, special meetings and conventions of this association in all cases wherein they are applicable and not inconsistent with these bylaws.

ARTICLE XVIII—Duties of District Nurses' Association

Section 1. It shall be the duty of each constituent district nurses' association of the Nurses' Association, Territory of Hawaii, Inc.:

(a) To require that all of its members have the qualifications enumerated in Article III, Section 1, of these bylaws.

(b) To send to the secretary of this association the names and addresses of all officers of the district nurses' association immediately following their election or appointment.

(c) To confer with the Committee on Constitution and Bylaws of this association before adopting any proposed amendments to its constitution and bylaws.

(d) To send to the secretary of this association a copy of the constitution and bylaws and all amendments adopted by the district nurses' association.

(e) To pay dues to this association as provided in Article IV, Sections 1 and 2, of these bylaws. Such dues shall be sent to the treasurer of this association with typewritten classified lists in duplicate of the members for whom dues are paid.

(f) To send to the secretary of this association the names and addresses of all those who are entitled to attend the annual convention as members of the voting body at least thirty (30) days before the opening day of the convention and to inform the secretary of all changes as promptly as possible.

(g) To nominate delegates to the biennial convention and special meetings of the American Nurses' Association in conformity with Article XIII, Sections 7 and 8, of these bylaws and to send the names of those nominees, with addresses, to the secretary of this association.

(h) To report to this association as may be required by the board of directors in order to comply with the constitution and bylaws of the Nurses' Association, Territory of Hawaii, Inc.

ARTICLE XIX—Official Organs

The American Journal of Nursing and the Inter-Island Nurses' Bulletin shall be the official organs of this association.

ARTICLE XX—Amendments

Section 1. These bylaws may be amended at any annual convention of this association by two-thirds vote of the accredited delegates present and voting. All proposed amendments shall be in possession of the secretary of this association at least thirty (30) days before the date of the annual convention and shall be appended to the call for the meeting.

Section 2. These bylaws may be amended at any annual convention by unanimous vote without previous notice.

Revised and Reprinted from Nurses' Association, Territory of Hawaii, Inc., Bylaws of 1952

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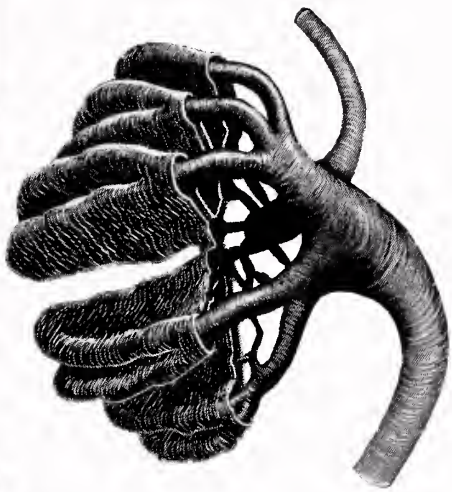
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WOMAN'S AUXILIARY

(*Continued from page 165*)

Organization—Mrs. Frederick Giles, Honolulu.
Program—Mrs. Mamoru Tofukuji, Maui.

County Auxiliary Projects

A courtesy mailing list is one successful way to interest new members and offer hospitality to future prospects. Newly arrived doctors' wives are sent a letter of explanation about the woman's auxiliary, newsletters, and meeting notices. Of course, if some member can follow up with a personal invitation to the meetings, so much the better, but the regular announcement insures that all eligible persons know they are welcome and are informed of the time and place of meetings. If the date is recorded when a name is placed on this list it is a simple matter to determine when to send an application for membership to each, and should there be any question of eligibility, it can be determined before the dues are accepted and the membership card issued.

This suggestion for a courtesy mailing list is furnished by the Honolulu County Medical Auxiliary. Assuredly, the number of prospective members there is larger than on any neighbor island but the consequences of an oversight through haphazard invitations are equally embarrassing everywhere.

Regular members check an information card showing what activity they can best help with. There is an explanation sheet to tell about the various committees and ask each member to give an hour or even 30 minutes in order that the auxiliary can be a vital help to the doctors. Since there are times when some of us cannot spare even a few minutes here is a thought from Honolulu president, Kay Benson, "Even the few who can give no time at all, at present, can contribute immeasurably by just paying dues. By that means, we help indirectly in presenting a lei to a distinguished guest, in sending flowers to a doctor's wife in the hospital, or in mailing a newsletter to keep you informed of the auxiliary's activities."

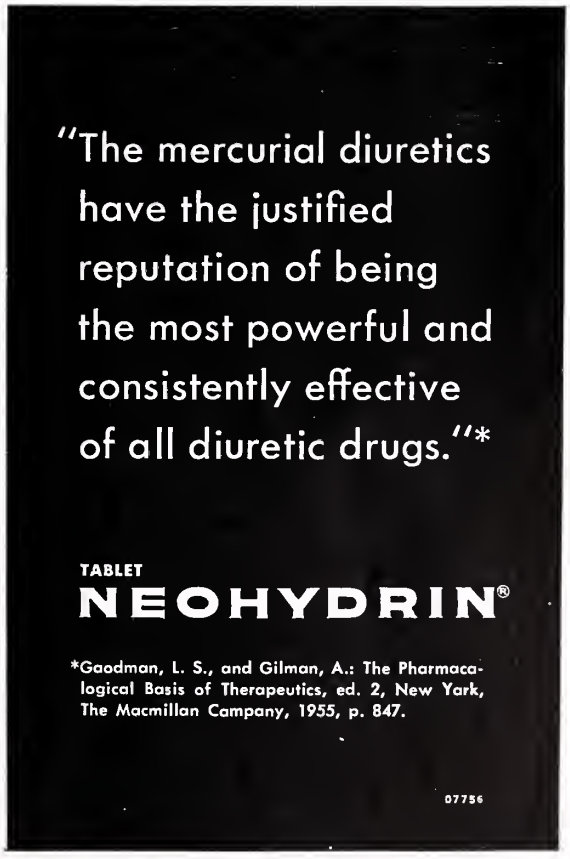
The September meeting of the Honolulu auxiliary was a well planned program to encourage friendly relations between their own members and other women's organizations. About twenty presidents of women's groups were invited to attend. This was an outstanding example of public relations as Dr. Hess recommended, as national tells us again and again, and as stated in the number one objective of our constitution.

Further promoting the program recommended by mental health was the speaker's subject and the topic of the movie short. Dr. William Stevens' talk, "9 out of 10" was on how we can help develop the new early mental treatment center proposed for The Queen's Hospital. A brand new movie short "1 out of 10" showing behind the scenes in our Territorial Hospital was presented. (Note to other auxiliaries and medical societies: This 30 minute film is available for use for a fee of $1.50.)

Two other projects which the Oahu doctors requested the auxiliary to participate in are voting registration and the Diabetic Detection Drive. Over a hundred calls were made to doctors and wives who had not registered to vote. The telephoners reported that this reminder was received with courtesy and appreciation. The services of the auxiliary presumably are helpful in the Diabetic Detection Drive as this is a repeat request from a previous year.

Members and guests of the Maui County Auxiliary enjoyed a dinner meeting at the home of Mrs. Robert Cole, in Spreckelsville, August 14. Mrs. John Sanders was co-hostess. Mrs. J. Alfred Burden, delegate, reported on the House of Delegates meeting. These appointments were announced:

Mrs. Seiya Ohata—Maui representative, W.A.H.M.A. nominating committee.
Mrs. Mamoru Tofukuji—News from Maui for Auxiliary section in Hawaii Medical Journal.
Mrs. Harold Kushi—Program Chairman.



The French call it "Aperitif".....

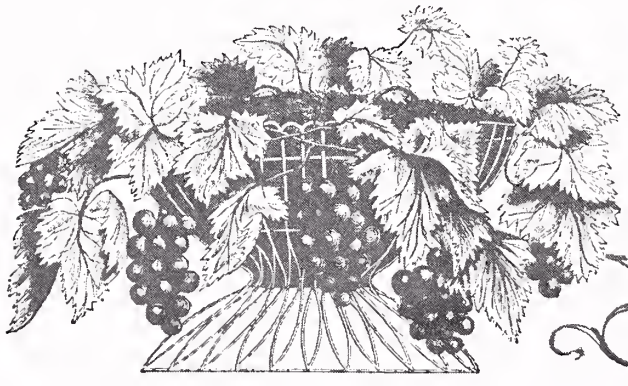


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We now know *why* a glass of Port, Sherry, Burgundy, Sauterne—
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the digestion as well as the appetite
of your geriatric, post-surgical or convalescent patients.

We know, moreover, that wine possesses significant vasodilating, diuretic and relaxant properties of value in the field of cardiology,
that its moderate content of alcohol is metabolized readily
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bedtime affords a valuable aid to normal sleep and may
even obviate the need for sedative drugs.



May we send you a copy of "Uses of Wine in Medical Practice." Just write to: Wine Advisory Board, 717 Market Street, San Francisco, California.

CASE REPORT

(*Continued from page 150*)

were removed under sterile surgical technique at 1:00 p.m. Smear, culture, antibiotic sensitivity tests from both eyes were ordered. Following removal they were irrigated with a solution of 2,000 U. per cc of penicillin and 5 mgs. of streptomycin. They were then placed in sterile containers on a dental roll moistened with normal saline and refrigerated, at 4 degrees C. In the interim, the patient was called from his home in Kahuku and admitted to the hospital by 6:00 p.m.

Preoperative Preparation

The preoperative orders included a complete blood count, urinalysis and a soap-suds enema. 400,000 units of Crysticillin were given by intramuscular injection. At 7:00 p.m. the patient was also given 3 grains of Nembutal by mouth and hypodermic injection of 100 mg. of Demerol. He was taken to the operating room at 9:00 p.m.

Surgical Technique

The usual local anaesthetic consisting of 0.5% pontocaine drops and 2% xylocaine with 1:1000 adrenalin by retrobulbar injection and facial akinesia were used. A bridle suture was placed under the superior rectus muscle. The recipient cornea was lightly marked with a 6 millimeter corneal trephine over the scar. Two double armed overlying 6-0 silk sutures were inserted into the cornea, 1 millimeter distally from the proposed graft, in a figure-of-8 fashion. The sutures were then lifted and temporarily placed nasalward and temporalward past the limbus. The trephine was then reapplied with the instrument held exactly at right angles to the plane of the cornea and the diseased cornea was removed. The same sized trephine was used to cut the donor cornea. The donor cornea was then placed in the defect and the overlying sutures were pulled back in place over it and tied. Four additional 6-0 black silk sutures were also placed between the donor and recipient cornea at the 10, 1, 4, and 7 o'clock meridians. 1% atropine was instilled and both eyes were bandaged.

Post-Operative Course

The post-operative course was complicated by iritis. This responded to 1% atropine locally and Meticorten and chloramphenicol orally. The sutures were removed under general anaesthesia at the end of the third post-operative week. Two months following surgery, the left eye was quiet and the graft was clear. Four months after surgery, the graft remained clear and the vision in the operated eye could be improved to 20/50 with corrective lenses.

Comment

Corneal transplantation has now come of age. In 1955, one American and one English textbook were published on the subject. The aim in the majority of cases of keratoplasty is to improve vision. However, a few cases have been done for cosmetic or therapeutic purposes. The final result depends largely on case selection.

Most authorities agree that good results can be anticipated in cases of central corneal opacity,

(*Continued on page 228*)

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IN MEMORIAM—DOCTORS OF HAWAII

(*Continued from page 160*)

F. Leslie Miner

F. Leslie Miner was born in 1854 at Richford, Vermont, the son of L. W. Miner, prosperous farmer and merchant. When only a child, the family moved to Abercorn in the district of Bedford, Quebec.

He attended local schools, Montpelier Seminary in Vermont, and at 19 matriculated at McGill University at Montreal from which he graduated in 1877 receiving his M.D. and C.M. He also studied further in London and in continental colleges and hospitals.

Because of his friendship with Sir Andrew Clark of London, Dr. Miner gained the coveted appointment as surgeon of the "Priscilla," the first ship to bring Portuguese laborers to Hawaii. While awaiting the sailing of the "Priscilla" in Madeira, Dr. Miner earned his first medical fee by treating a wealthy Belgian lady tourist, who presented him with a valuable diamond ring. After a voyage around the Horn of 116 days, the "Priscilla" arrived in Honolulu September 29, 1878. All passengers were in good health and there had been no deaths.

Dr. Miner remained in Honolulu until 1880 when he traveled to the United States visiting there and at his home in Canada. He then went to London where he became a regular candidate for Royal College membership. After a few months in London, the doctor developed a bronchial condition and went to Germany where he entered Heidelberg University and took the full pathological course under Professor Arnold. Subsequently, he studied in hospitals in Berlin and Vienna for about a year, following which he traveled in Switzerland, Italy, Greece, Turkey, the Holy Land, and Egypt. In 1886 Dr. Miner returned to London and passed his final examinations for the Royal College of Physicians in July, receiving the degree of M.R.C.P.

In Germany Dr. Miner met Miss Rose Atcherley, daughter of a wealthy Manchester merchant, who was in Stuttgart pursuing her musical education. Soon after the doctor received his degree they were married and sailed for America where the young couple spent the winter of 1886-1887 visiting friends in Canada and New England.

Dr. and Mrs. Miner returned to Honolulu in April, 1887. Entering private practice in Honolulu, Dr. Miner was physician to many prominent local people. In 1917 he gave up his practice and returned to California.

Dr. Miner gained much attention by owning the first automobile in the Islands, an electric buggy capable of 25 miles per hour. In 1931, on his last visit to the Islands, he had with him a car capable of making 90 miles per hour!

Dr. Miner died April 25, 1931, in Honolulu while on a visit.

Auguste Jean Baptiste Marques

Auguste Jean Baptiste Marques was born in Toulon, France, on November 17, 1841. His father was half French and half Spanish and was a general in the French Army. His mother was half English and half Scotch, and the daughter of General Cooke of the Brititsh

(*Continued on page 194*)

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IN MEMORIAM—DOCTORS OF HAWAII

(*Continued from page 192*)

Army. Auguste's boyhood was spent in Morocco, Algiers, and the Sahara.

His early ambition was to become a doctor, but his mother wanted him to become a scientist. As a compromise, he acquired a medical and scientific education but agreed not to take his diploma or to practice medicine. After four years in medicine, he was valedictorian of his class at the University of Paris but, true to his agreement, never accepted a diploma. He also received a musical education.

For some years he was connected with the Bureau of Agriculture in Paris.

Shortly after his mother's death in 1875, Dr. Marques started on a trip around the world. Arriving in Honolulu Christmas Eve of 1878, he decided to stay over between steamers. He so liked Hawaii that he canceled his passage and from then on made the islands his home. In 1880 Dr. Marques purchased a 400 acre tract near Punahou School for $10,000. He became an instructor of music at Punahou. He was a charter member of the Philharmonic Society of Honolulu.

Dr. Marques bored the first artesian well in Honolulu. His project met considerable opposition from some residents, who circulated a petition asking the king to refuse permission.

King Kalakaua sent Dr. Marques to Russia on a diplomatic mission in 1886. From 1890 to 1891 he served in the Hawaiian legislature.

In 1893 Dr. Marques organized the Theosophical Society in Honolulu. In 1899 he served as secretary for the Australian section of the society and went to Australia. From there he was sent to India as a delegate of both Australia and the U.S.A.

On June 7, 1900, Dr. Marques married Evelyn M. Oliver, who was manager of the Woman's Exchange.

Dr. Marques was made chancellor to the French consul in 1903. In 1910 he became consular agent for France and in 1912 he was promoted to consul, a position he held until his death.

He also represented Russia, Panama, and Belgium. He was appointed consul for Russia in 1906, a position he held until the overthrow of the czar. In 1909 he was made consul for Panama and in 1914 he became consul for Belgium.

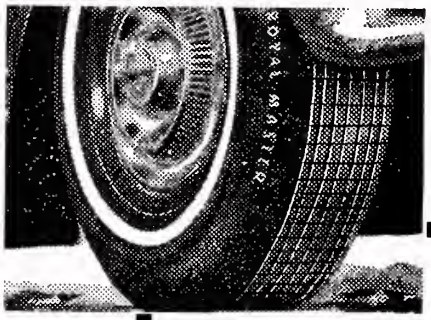
Dr. Marques spent one year in Portugal studying and took a degree of doctor of science at the University of Lisbon. Becoming a member of the Research Society there, he gave many lectures on the Hawaiian Islands.

He was instrumental in bringing a colony of Portuguese to Honolulu. At his own expense he built a school house for them and sold them lots on long time credit to encourage them to become homeowners.

Dr. Marques' scientific investigations were many and varied and included the study of leprosy.

During his lifetime Dr. Marques was the recipient of a great number of honors and decorations. He was a Chevalier of the Legion of Honor of France. His was the first decoration of the Order of Kapiolani bestowed by King Kalakaua. He held the Order of Commander of Christ. The Geographical Society of Lisbon presented him with a medal for his reports on Samoa. For his work in the preparation of a Hawaiian constitution he was awarded the Order of Commander of Kalakaua.

(*Continued on page 197*)



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IN MEMORIAM

(Continued from page 194)

For his investigations in the South Seas he received the Order of Palms, Academic, from France. His research in the field of leprosy brought him the Legion of Honor. The Ordre du Mérit Agricole was given to him for his studies on sugar, pineapple, and sisal. Dr. Marques was awarded a medal from the Czar of Russia. King Albert presented him with the Order of Chevalier Leopold Belgique for his work for Belgium during the World War. His investigations and monographs on leprosy brought him the Order Officier Dragon d'Annam from Indo-China.

Dr. Marques died March 13, 1929, in Honolulu at the age of 87.

Algernon Sydney Nichols

Dr. Algernon Sydney Nichols of Haverhill, Massachusetts, died February 7, 1877 at Hilo, Hawaii. He was about 35 years of age at the time of his death.

James S. Smith

Dr. James S. Smith, a native of Ohio, lived at Hilo for some months prior to his death, which occurred April 7, 1879, in Hilo. An inquest held that he had met death by an over-dose of chloral hydrate, administered by himself. Dr. Smith was 40 years old at the time of his death.

COUNTY SOCIETIES

(Continued from page 166)

The motion was carried.

There being no further business, the meeting adjourned to the lanai for refreshments.

* * *

A special membership meeting of the Honolulu County Medical Society was convened Wednesday, October 3, 1956, at 7:30 P.M. in the Mabel Smyth Auditorium. Dr. J. M. Felix presided and approximately 118 members were present.

Subjects for discussion were limited to the following items: (1) Proposed increase in fees for HMSA Fee Schedule. (2) Establishment of a new fee schedule for the Dependents' Medical Care Program. (3) First reading of amendments to Bylaws as recommended in recent report of Medical Care Plans Committee.

Amendments to Constitution and Bylaws. Dr. Felix advised that this was only a first reading and no action by the membership was necessary at this time. He stated that this amendment fulfills the Society's action at its last special meeting to create a Medical Care Plans Committee as one of its standing committees.

Proposed Increased Fees for HMSA Fee Schedule. In a letter dated May 1, 1956, HMSA informed the Medical Society that they had $50,000 surplus available for increases in their surgical fees and requested the Fee Adjustment Committee to review this matter.

A letter from the Fee Adjustment Committee was read which stated that they had reviewed and acted upon the request from HMSA and were submitting a

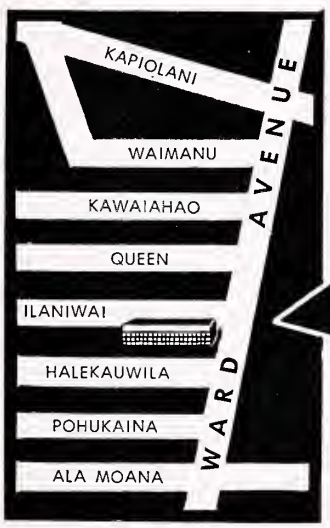
(Continued on page 198)

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COUNTY SOCIETIES

(*Continued from page 197*)

proposed list of increases in the HMSA Fee Schedule for approval by the membership. The letter also stated that the Committee had attempted not only to increase the surgical fees but, where possible, also to increase the medical fees.

A motion to accept the Fee Schedule was made and seconded.

A pro and con discussion followed.

Dr. Chung-Hoon then moved that the motion before the house should be postponed indefinitely. The motion was seconded.

It was brought out that the new relative value fee schedule being worked on by the Fee Adjustment Committee has a long way to go yet and if this matter is postponed now, the doctors will lose this opportunity to increase the HMSA Fee Schedule. Also, this relative value fee schedule was never intended to apply to any insurance fee schedule. In regard to the $50,000 being divided up only among the surgical fees, it was brought out that the surgeons are the only ones in the Society who accept the present fee schedule as payment in full for persons who are under certain income groups. This raising of the fees for surgeons is to make it a more equitable fee. Also this money is not money which the doctors have earned.

The motion to postpone indefinitely the proposed increase in the HMSA Fee Schedule was voted upon, but failed to carry.

Further discussion ensued and the following points were brought out.

This increase in fees applies to all plans, the Community Group Plan as well as the Basic Plans. The Medical Consultant's fee, however, is not a benefit in the Basic Plan, and applies only to the Community Group Medical Plan.

This fee schedule in no way binds the Society permanently and can be adjusted by the Society at any time in the future.

In answer to an objection that no increase was made in the fee for an office visit, Dr. Faus explained that an increase from $3.00 to $4.00 for an office visit would cost the plan approximately $285,000.00 and only $50,000 is available now.

This $50,000 increase in fees has nothing to do with the 20% deduction in the Community Group Medical Plan. They are not related in any way. The process for increasing the fee schedule started a long time ago.

Dr. Giles' motion to accept the Fee Schedule was then voted on and was carried with four dissenting votes.

Establishment of a Fee Schedule for the Dependents' Medical Care Program. Mr. Kennedy, Executive Secretary, presented a brief outline of the Dependents' Medical Care Program. He also reviewed the final draft as received from the Department of Defense. A short question and answer period followed.

A letter from the Fee Adjustment Committee was read in which the committee recommended that the California Relative Value Schedule, a copy of which had been circulated to each member, be adopted for the Dependents' Medical Care Fee Schedule. The committee also recommended that certain base fees and conversion factors be applied to this schedule.

It was moved and seconded that the fee schedule as recommended by the Fee Adjustment Committee be adopted. The motion was carried.

There being no further business, the meeting adjourned to the lanai for refreshments.

R. T. West, M.D.
Secretary

Kauai

The regular meeting of the Kauai County Medical Society was called to order at 8:30 P.M. on August 7, 1956, at the G. N. Wilcox Memorial Hospital library by the president.

Members present: Drs. Boyden, Brennecke, Cockett, Goodhue, Ishii, Kim, Kuhlmann, Kuhns, Masunaga, Wade, Wallis, and Schilling.

The subject of Hawaii Medical Association committees was discussed with appointments made as follows:

Diabetes Committee Dr. Kuhlman
Emergency Medical Service Comm.....Dr. Wade
Legislative Committee.....Dr. Brennecke
Postgraduate Committee Dr. Fujii
Scientific Program Committee.....Dr. Fujii
Public Service Committee.....Dr. Wade
Chronic Illness Committee.....Dr. Cockett

It was moved and seconded to send a letter of condolence to the wife of the late Dr. Maxwell Boyd.

Meeting adjourned.

Stanley Schilling, M.D.
Secretary

Maui

A special meeting of the Maui County Medical Society in conjunction with the dentists and other interested persons was called on August 14, 1956, to discuss the possibility of abolishing the positions of government physicians as they are now and compensating any doctor for doing work for the indigents and medically indigents.

Members present were: Doctors Patterson, St. Sure, Wong, Tompkins, Burden, Underwood, Sanders, Otsuka, Fleming, Izumi, Tong, Kashiwa, H. Kushi, Ohata, Totherow, McArthur, Moran, Cole, Kanda. Dentists present were: Doctors Stitsher, Maehara, Robinson, Shimokawa. Other guests were: Doctors Kemp, Avakian, Smith, Iaconetti, Mrs. Sugino and Mr. Lane, Chief of Police.

The main topic of discussion, namely, the abolishment of the position of government physician was now brought up. Dr. Kemp of the Board of Health explained that the salary of the government physicians as such would not be diverted away from the so-called government physicians, but that the same end could be attained by making all the physicians government physicians in order that the allotment for government physicians could be prorated among these doctors on a patient, office, or house call basis. She went on to explain that no fees-for-service would be forthcoming for indigent patients treated in the hospitals or for professional services as such. Many diverse views were expressed.

Mr. Lane, Chief of Police, explained that in the past five years, 173 coroner's post-mortem examinations had been done and that there were 31 during the past year. It was suggested that since Dr. Moran was a pathologist, he might also be appointed as a coroner's physician and be put on a retainer to do all post-mortem examinations on coroner's cases. In the discussion it was brought out that it takes 2½ to 3 hours for the pathologist to do a post-mortem examination and it was suggested that more discretion could be used on ordering of autopsies. Mr. Lane stated that

(*Continued on page 200*)



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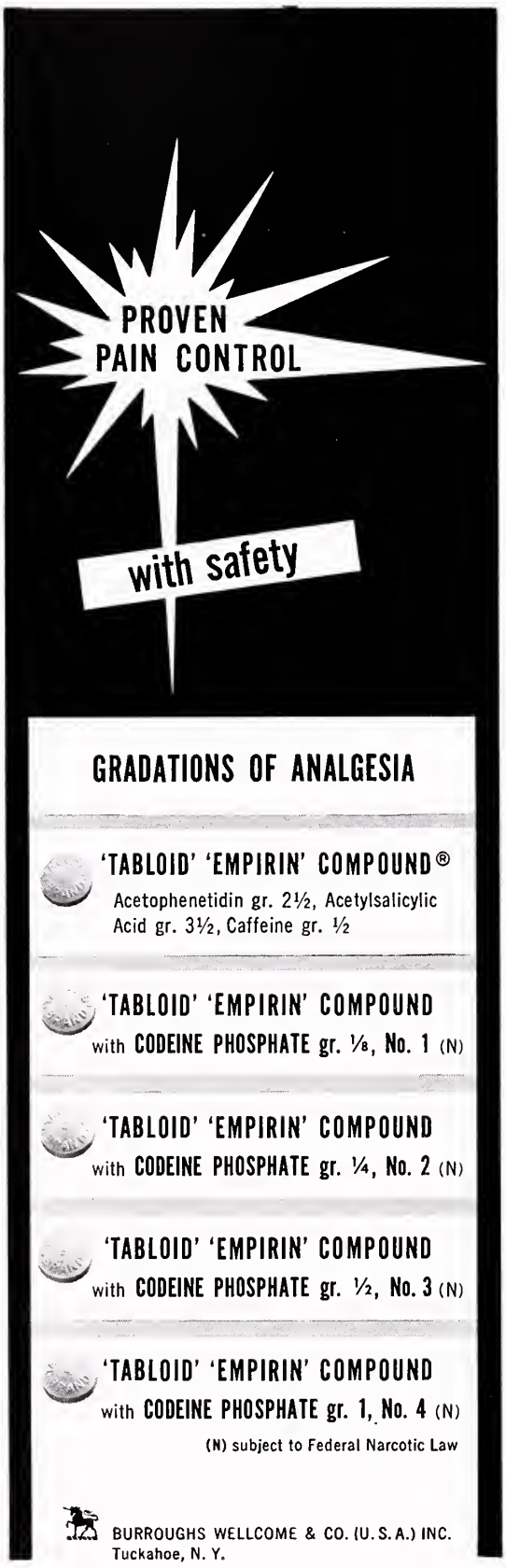
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COUNTY SOCIETIES

(*Continued from page 198*)

in every criminal death a positive cause of death must be determined.

Dr. Sanders moved and Dr. Kushi seconded that a committee of the Medical Society be appointed to study the possibilities of taking care of indigents on a different basis and the creation of the position of coroner's physician and to poll the members on any plan developed to see if they approve or disapprove. The motion passed.

Dr. Burden moved and Dr. Cole seconded that the committee be: Chairman: Dr. Patterson. Members: Doctors McArthur and Otsuka. Motion passed.

As a final item of business, a letter from Dr. Butler of Molokai pertaining to the employment of a government physician for the east end of Molokai was read. Dr. Totherow made comments on the letter.

Meeting adjourned at 10:20 P.M.

MAMORU TOFUKUJI, M.D.
Secretary

UMI MAKAHIKI I HALA*

Personals

Dr. Thomas W. Cowan, formerly of Wailuku, Maui, is now associated with The Clinic, Honolulu, in the Department of Ophthalmology.

Dr. and Mrs. Edmund L. Lee of Honolulu are the parents of a son Edson, their second child, born September 15 in the Kapiolani Hospital.

Dr. Victor G. Heiser, noted public health authority, visited recently in Honolulu on his way to Guam for the dedication of the new Navy Medical Center. While here he lectured at the Mabel Smyth Building and praised the Hawaii plantation medical care as "the best in the world for plantation workers."

Dr. Leslie A. Vasconcellos has recently become associated as a partner with Dr. Louis Gaspar in his office in Honolulu. Dr. Vasconcellos has been resident physician at St. Francis Hospital for the past year, following his discharge from the Army.

The Leahi Hospital has been fortunate in securing the full-time services of an outstanding thoracic surgeon, **Dr. Paul Gebauer,** formerly of Cleveland, Ohio.

* Ten years ago. From Volume 6, Number 2, November-December, 1946.

(*Continued from page 167*)

pointment of this committee. It was appointed to advise the Health Department and also the HMA what to do in this field. The committee began to wonder if that was enough. After a while the committee made recommendations to the Health Department, some were carried out and some were not. Also recommendations were made to the HMA and again some were followed up and some were not. Most of them were not and that discouraged the committee.

Dr. Yamauchi added that he thought Dr. Quisenberry had covered the matter well. The chairman of the national group was here a while back. The Committee felt that since it was organized, six years ago, that many of the things have been done nationally and that this type work is out of line without financial backing which we lack to carry on a committee. The national group has been disbanded and their work has been taken over by four separate divisions which were backed by the national group and now AMA is just proposing a study of this problem. Our Oahu Health Council has gone ahead and developed a rehabilitation center. As far as future objectives for such a committee is concerned, he said he did not know whether or not there is a place for it.

Dr. Quisenberry stated that he felt there is a need for such a committee. There are still some critical needs in some fields, especially in institutions. Dr. Walker is concerned because he is getting some extra beds in his institutions. There are now more chronically ill people in the territory. There are still some needs. He said he felt there is a need from this committee to advise both the Health Department and the HMA what should be done.

Dr. Stevens thought that there was a particular need in relation to mental illness. Governor King has authorized a survey of mental health and some other phases of chronic illness. Dr. Haertig is doing something in the same field and so maybe our small group is duplicating work done by tax supported funds.

Dr. Boyden asked Dr. Mills if he had found there was a need for additional beds.

Dr. Mills said their investigations have not gone on and they have not had a meeting since July.

Dr. Boyden went on to say that the question seems to be whether or not this committee should continue simply as a consulting body to the Board of Health or whether it should do some investigating.

Dr. Johnsen said it might be well to dissolve the committee at this time.

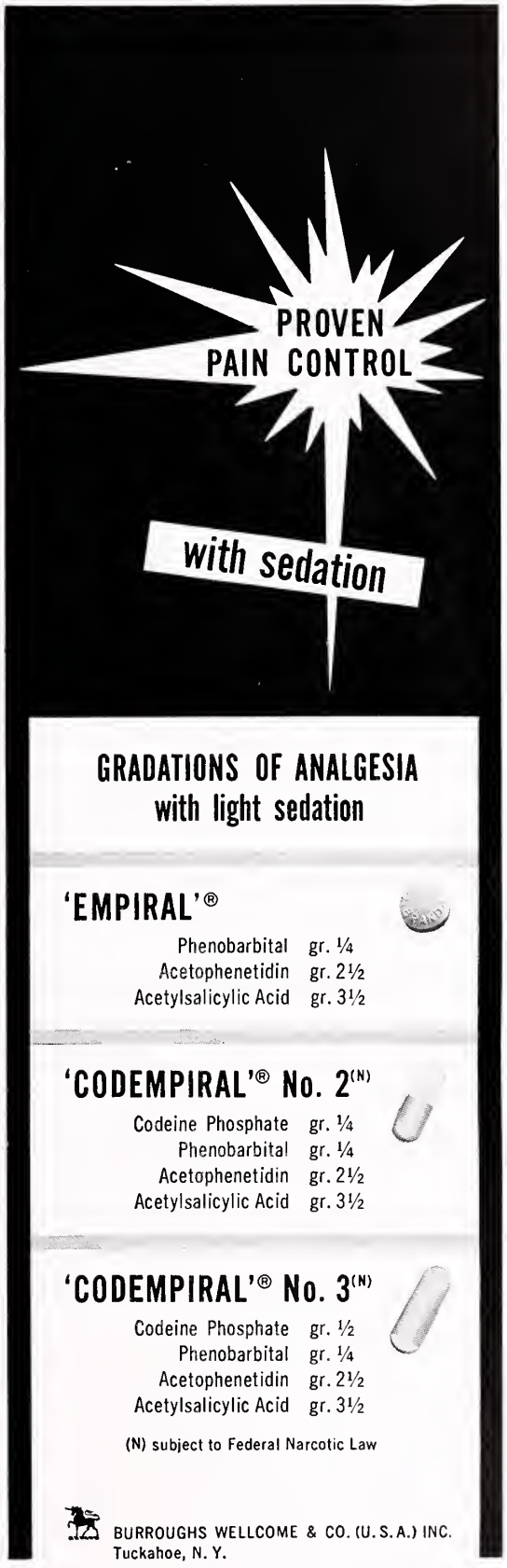
Dr. Quisenberry said that rather than discontinue the committee he thought it should continue on a consulting body basis and made the motion that the Chronic Illness Committee continue on as a consulting committee to the Health Department or any other body seeking consultation.

Dr. Bailey seconded the motion and it carried unanimously.

MEDICARE

Dr. Boyden said he had been criticized by various men from all the islands, Kauai not excepted, for giving the executive secretary authority to send a cable to Dr. Lull informing him that the HMA had been appointed fiscal agent for the Dependents' Medical Care Plan. He then gave a chronological resume of all the events that led up to the necessity of making this decision. He pointed out that he was not at all certain whether he

(*Continued on page 205*)



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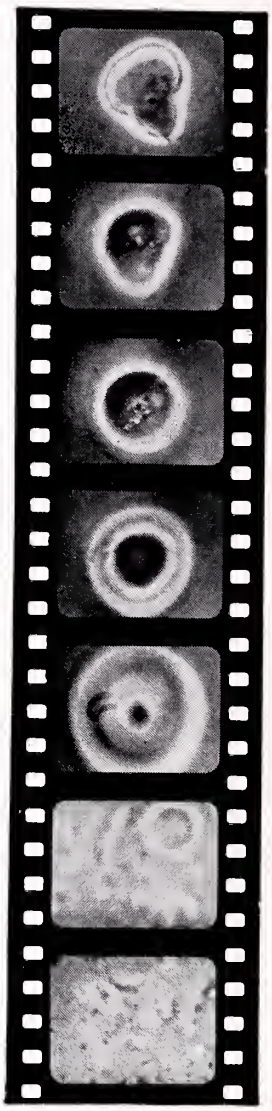
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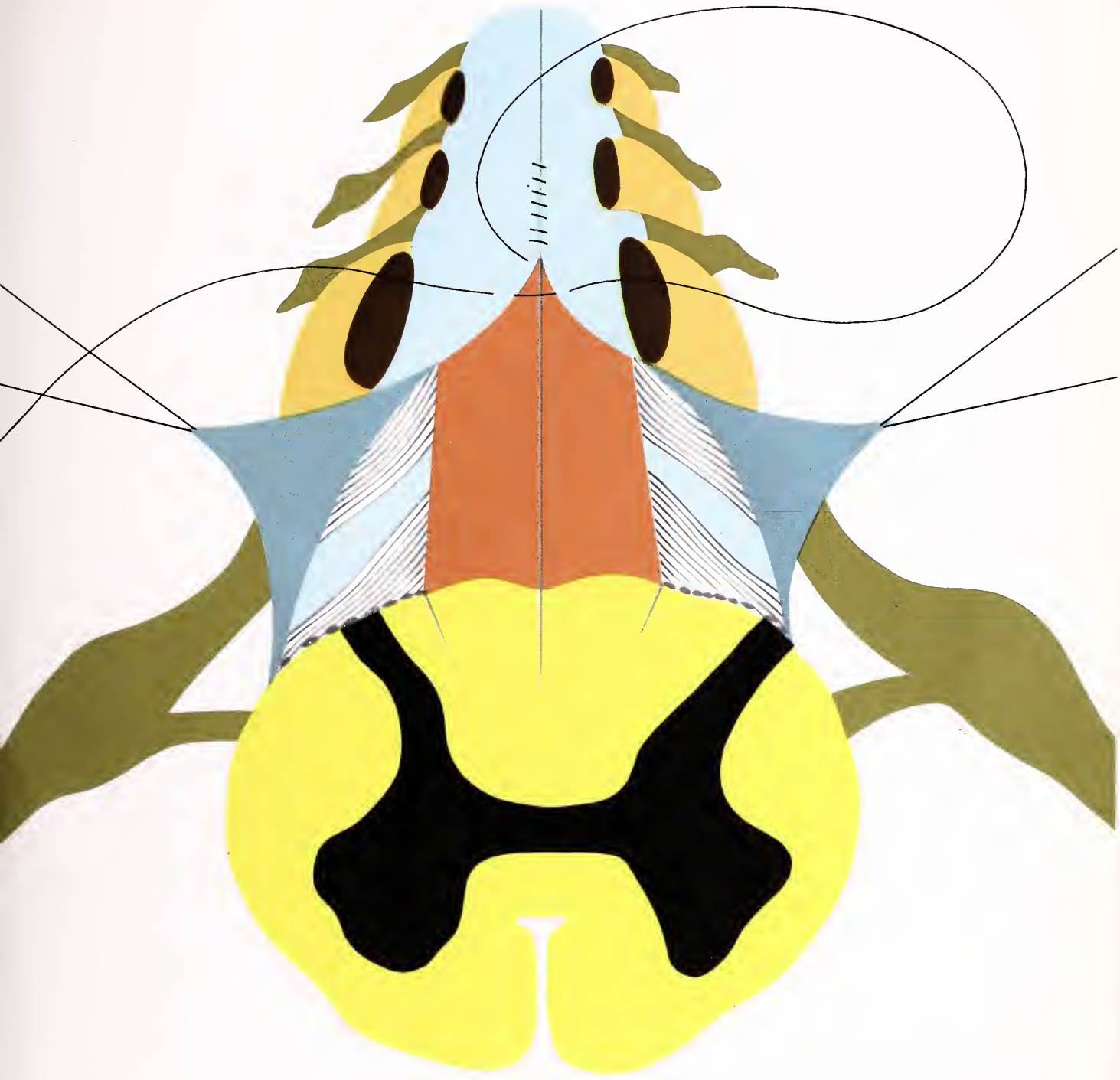
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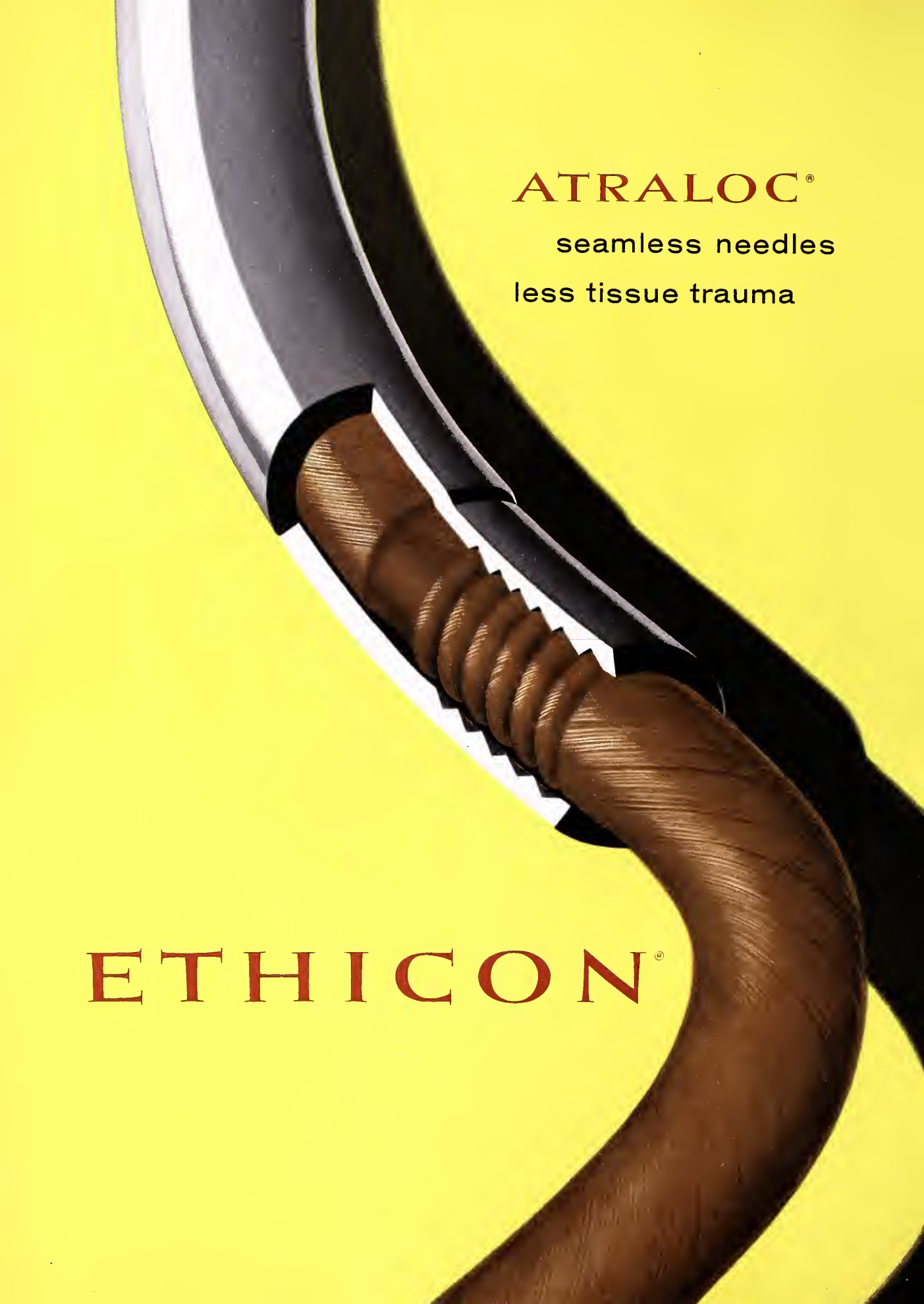
References: 1. Davis, C. H.: J.A.M.A. *157*:126 (Jan. 8) 1955. 2. Davis, C. H.: West. J. Surg. *63*:53 (Feb.) 1955. 3. Davis, C. H., and Grand, C. G.: Am. J. Obst. & Gynec. *68*:559 (Aug.) 1954. 4. Davis, C. H. (Ed.): Gynecology and Obstetrics (revision), Hagerstown, Md., W. F. Prior, 1955, vol. 3, chap. 7, pp. 23-33. 5. Draper, J. W.: Internat. Rec. Med. *168*:563 (Sept.) 1955.



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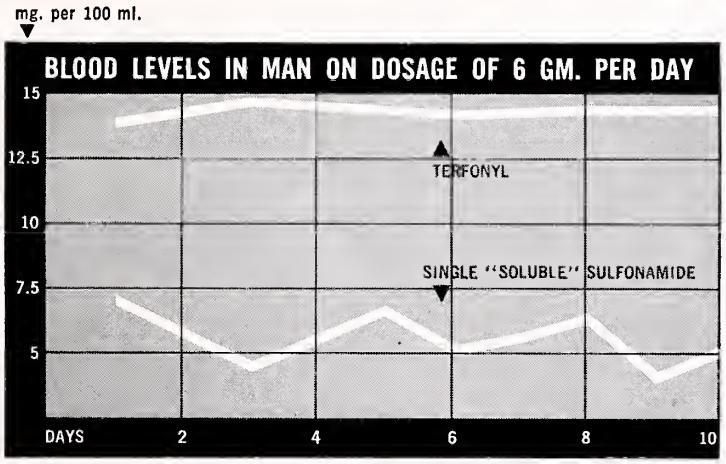
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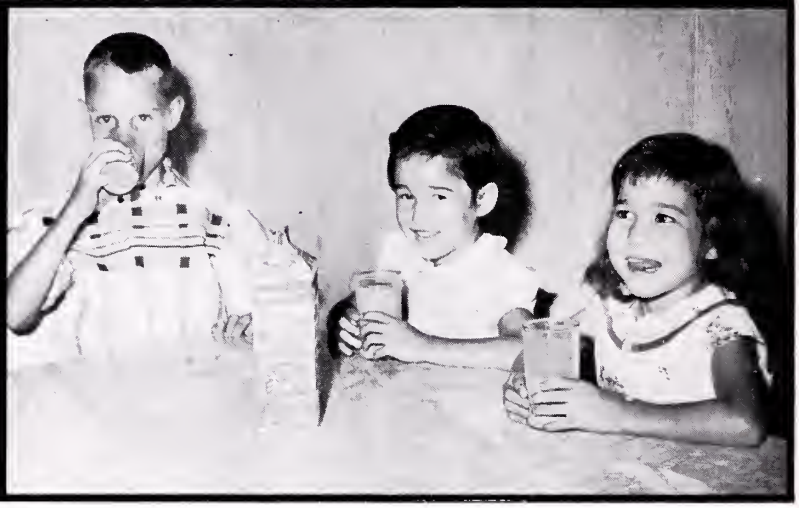
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HAWAII MEDICAL ASSOCIATION

(*Continued from page 201*)

had authority to do what he had done and added that we had received no answer from AMA that this decision had been accepted.

Dr. Kuhlman stood to express the Kauai point of view. He said they had discussed the problem and felt it only fair that all members be advised. When he was told of the decision he contacted HMSA insurance carriers, and Dr. Boyden, and reported back to the society. The report in essence was that the issue was one of the HMA vs. the HMSA. The Kauai Society came to the conclusion that (1) from a business standpoint we cannot expect any profit in it. It is a non-profit program to the fiscal agent. At the end of the year you must present some four and a half pages of cost accounting and so the HMA can't expect to make any profit and if they do make any profit out of it, they are jeopardizing their tax status. (2) Statistics are voluminous. In the first year this will perhaps not be very high and will not involve too many people, work, and expense for the HMA but taking it from a long range standpoint, there is a different picture. It is only the breach in the dam and there will be further things added on to it. Should the HMA set up ledgers, hire personnel, etc. to take care of this? Which islands are going to benefit from PL 569? That depends upon the commanding officer of Tripler and his decision on how many he is going to release. Therefore, it is going to benefit the outside islands. If the Defense Department takes a look at our voting and we do not have unanimity of opinion, they may turn around and appoint someone entirely different, say Mutual of Omaha. The 17 to 14 vote of the Honolulu County Society does not indicate the thinking of the majority of the doctors in Honolulu. With that the only fair way that we as delegates can settle this matter is by referendum and also indicate and circulate with the referendum the discussions taking place here tonight, and he so moved.

Dr. Burden seconded the motion.

Dr. Yee said tonight's meeting was not intended to involve personalities and went on to say he didn't know where Dr. Kuhlman got his information. If he states that a profit is not to be realized, that would also eliminate HMSA as it is a nonprofit organization. Another point is that looking at it from a long range standpoint, you should look at the circular that was passed by the Defense Department and you will find that the Coast Guard and Public Health officers, as well as Coast and Geodetic Survey, are included and later on perhaps other federal workers will be involved. He went on to say that if the segment of the population (which represents one in twelve in Honolulu) becomes involved that would mean about 40,000 here, and that the HMA should have its finger on the pulse of all medical matters in the Territory.

HMSA is trying to get this business and if it is not profitable, why are they trying so hard to get it? The HMA can take care of its own business. We have a Bureau of Medical Economics. It is a going organization. The information that has been gathered about the handling of the Dependents' Medical Care Plan indicates that it will not involve machines or a corps of clerks or anything of that nature. At the most it might involve one or two additional clerks. We should not give our business over to an organization over which we have very little control. We might lose money the first year. If we do, you can be sure the HMSA would not want it and if we decide we don't want it, we can tell the Defense Department to appoint their own fiscal agent.

Dr. Arthur explained that he was on the Board of Governors and when this thing came up he was a little bit led astray because he was told the HMA wasn't able to handle it and he mistakenly voted for HMSA. The matter was not presented fairly at the Board of Governors meeting. There is no reason for giving money to HMSA that could come to us.

Dr. Quisenberry asked to have Mr. Kennedy, who was present as a guest, clarify a few points.

Mr. Kennedy explained that when he was first asked about whether or not the Bureau of Medical Economics could handle this, he did not know because he had no idea what work would be involved. He was asked by Dr. Felix to go down to the VA and look into the procedure followed in the Home Town Program on the assumption that this work would be similar, and it looks like it will be. After investigation it became clear that the Bureau could handle it but not in their present space.

Actually, how much work is going to be involved, and can we make money, are two questions that cannot be answered at this time. The Bureau could distribute the profits to the various component societies in any way agreed upon because although the Bureau is a full tax paying organization, its bylaws are set up so that no dividends on the stock can be paid. The Bureau must spend all money it makes. Mr. Kennedy again reiterated that the Bureau could not handle this with its present office space.

Dr. Quisenberry said that the main thing was whether we would stand to lose a great deal of money the first

(*Continued on page 206*)

"Patients without primary renal disease, but with albuminuria and high nonprotein nitrogen due to congestive circulatory changes, can be adequately and safely treated with Neohydrin for long periods of time."*

*Griffith, G. C.; Dimitroff, S. P., and Thorner, M. C.: Ann. Int. Med. 45:7, 1956.

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HAWAII MEDICAL ASSOCIATION

(*Continued from page 205*)

year and that Mr. Kennedy had answered that by saying we would start out on a very limited scale.

Dr. Batten said he would like to say something apropos of the long range point of view. It was his understanding that as things are now set up there will not be many dependents released on this island. The load at Tripler is estimated to be very low. To begin with it will probably consist of only the overload of OB cases. The added burden is going to be the Coast Guard. If that is the case, and we know there are very few members of the armed forces on the neighbor islands, there isn't going to be much to worry about because the Bureau of Medical Economics can take care of these cases without even adding anyone to handle the slightly increased load. If it works out, the Bureau of Medical Economics can grow. If it is going to lose money, it will lose money all over the country and nobody will take it. This way we have something that is ours. Why give it away?

Dr. Burden said it seemed to him that the term "HMA" and "Bureau of Medical Economics" were being used synonymously and it was his impression that one is territorial and the other Honolulu County and was it our intention to let Honolulu County run this business?

Dr. Kuhlman asked to clarify further the feelings of the delegates. He said we should get it straight from these men, each of whom represents 25 members from his society, if he is expressing his own opinion or that of his society.

Dr. Felix explained that the relation between the HMA and Bureau of Medical Economics would be similar to the set up now existing between the HMSA, VA, and HMA. If the Bureau of Medical Economics acts for the HMA in this program, there will be a contract between them to facilitate HMA's being the fiscal agent.

Dr. Bailey asked how they would handle the program on Kauai or Hawaii since they have no local offices.

Dr. Felix answered that it would be agreed to in the contract. He added that when the Community Group Plan was put up to a vote, it was passed by 15 to 13. In looking over the Veterans' Care Program he tried to get some figures on the profit. Out of the income of a little over $8,000.00, HMSA made at least 50 per cent profit. All HMSA does is pay the salary of one girl who has her desk at the VA office. He went on to comment that two people had said that HMSA was the doctors' plan and that he thought so too until Tuesday night when there was a meeting to try to reach some kind of an agreement with them. During the heat of the discussion one of the doctors asked if this is the doctors' plan and Mr. Pell, a member of the HMSA board for some eight years, answered that the HMSA was not the doctors' plan—it is responsible only to the members and subscribers. He was asked then why it was printed on HMSA literature that it was the doctors' plan and Mr. Pell said that was used only as a sales gimmick.

Dr. Bennett reported on his conversation with Dr. Hess when the latter was here and the special point that Dr. Hess made in warning us about the medical hucksters. He went on and said he had figures on the military dependents on the other islands and that there were two on Kauai, 32 on Hawaii, none on Maui, and 30,000 on Oahu. He closed by saying that if we don't control this, somebody else will.

Dr. Kim asked what the time element was.

Dr. Boyden explained that the Department of Defense is going to ask for representatives to come to Washington, but no one knows when. The plan goes into operation December 8.

Dr. Batten said that perhaps Dr. Kuhlman's motion is untimely and pointed out that our president has already designated the fiscal agent and so perhaps Dr. Kuhlman's motion should be voted down.

Dr. Kuhlman restated his motion that a referendum be circulated to the entire membership asking their preference for HMA or HMSA and should include tonight's discussion.

Dr. Yee got up and said he had expected Dr. Kuhlman to withdraw this motion and asked to be allowed to point out something. If it were sent out for a vote, there will be a lot of uninformed doctors who would receive it. Therefore it is only proper that it should be decided right here among doctors who have given the matter a great deal of study. That would be more democratic because ballots can be influenced.

Dr. Ing moved that we table Dr. Kuhlman's motion.

Dr. R. Nishijima seconded the motion.

The motion passed by a standing vote of 19 to 8.

Dr. Felix moved that we give the president a vote of confidence and approval of the HMA as fiscal agent.

The motion was seconded by Dr. Batten.

Dr. Fleming moved that the motion be tabled.

This motion was seconded by Dr. Rockett.

A standing vote was taken and 8 voted to table the motion, 19 against, and the discussion was resumed.

Dr. Kim brought up the question of whether or not the delegates' action was binding on all counties.

Dr. Kuhlman said it is not binding except by referendum.

Dr. Boyden asked if this House can make it binding for all component societies.

Dr. Yee said there was nothing in the bylaws that says that the delegates are bound, but that if the House of Delegates meets and makes a decision it is binding.

Dr. Kuhlman said the act is not necessarily binding on the individual county society.

Dr. Stevens said that if this were true, all actions taken by the House of Delegates would be in jeopardy.

Dr. S. Nishijima read Section 1, Chapter 6 of the bylaws referring to referendum.

Dr. Stevens said his vote for tabling Dr. Kuhlman's motion was based on the fact that we had already advised that HMA would act as its own fiscal agent and if we got a reply from AMA while getting a referendum, we would look pretty silly.

Dr. Felix restated his motion to approve of the president's action in designating HMA as our fiscal agent.

Dr. Batten seconded the motion.

Dr. Burden said that he believed there were between 25 and 30 doctors on Maui and although he realized that the greatest number of doctors and number of delegates ruled, he felt that the component societies should have their way.

Dr. Yee said that if this question is not going to involve the outside islands why are they so concerned.

Dr. Rockett said there was a lot closer ratio of patients to doctors on the outside islands and he for one had a military family that owes him $500, which he could collect if it were insured.

A show of hands was called on Dr. Felix's motion and it passed with an overwhelming majority.

An informal discussion of this subject ensued.

(*Continued on page 212*)

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improves function

resolves inflammation

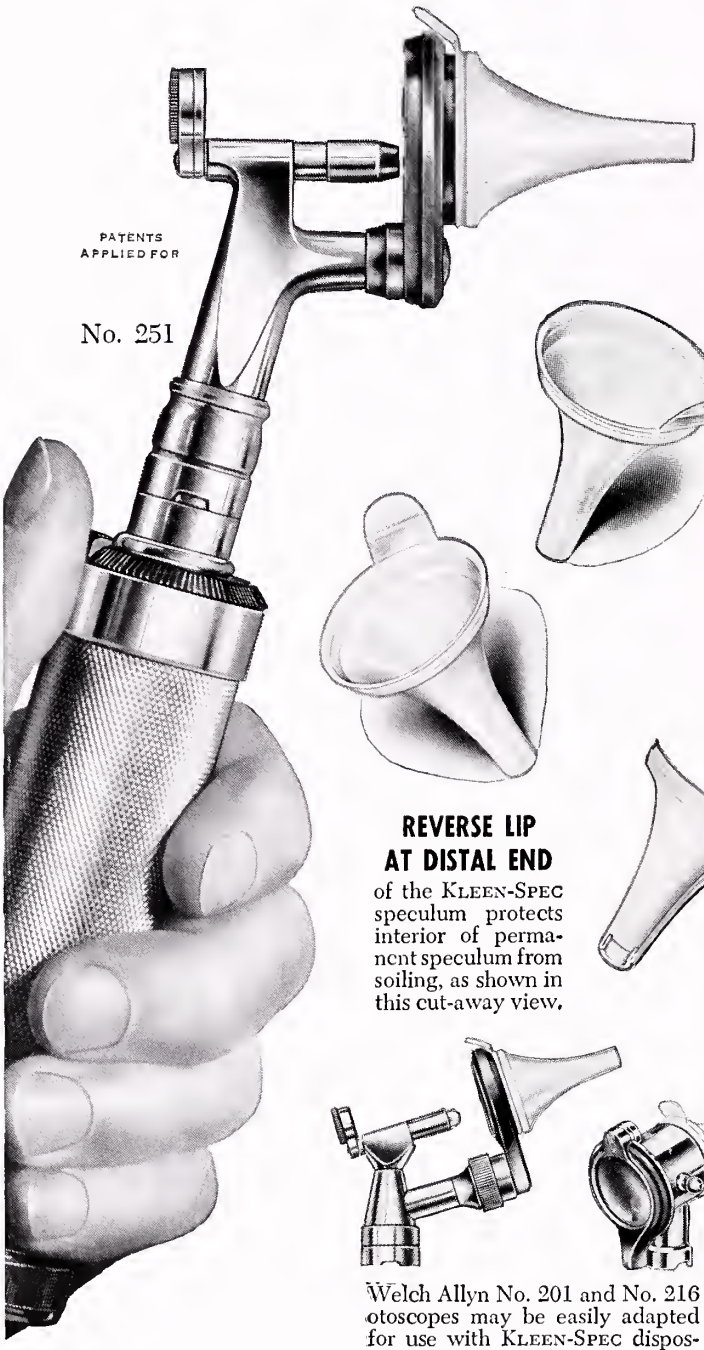
BUTAZOLIDIN being a potent therapeutic agent, physicians unfamiliar with its use are urged to send for literature before prescribing it.

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NOW– DISPOSABLE OTOSCOPE SPECULA



• Use a speculum once • Throw it away • Replace it instantly with a new one. That's the simple, sensible procedure you follow with new Welch Allyn KLEEN-SPEC otoscope specula. Gone is the danger of cross-infection, the nuisance of sterilization. Gone the problem of having enough clean specula. Packed in transparent tubes of 40 each, KLEEN-SPEC specula are $3.25 for 200.

You can use new KLEEN-SPEC disposable specula on your present Welch Allyn otoscopes with a simple, inexpensive adapter which costs only $2.00.

Or, you may prefer the completely new Welch Allyn No. 251 otoscope head, designed especially for use with KLEEN-SPEC disposable specula. It weighs only half as much as its predecessor, has clean modern lines and improved illumination. It fits all standard Welch Allyn battery handles. The No. 251 head, with 400 KLEEN-SPEC disposable specula, is $20.50.

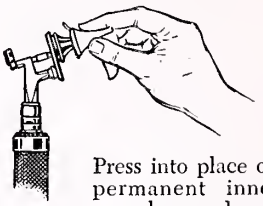


REVERSE LIP AT DISTAL END
of the KLEEN-SPEC speculum protects interior of permanent speculum from soiling, as shown in this cut-away view.

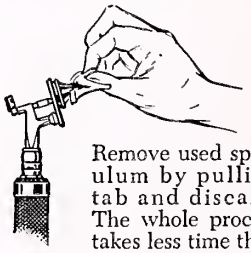
Welch Allyn No. 201 and No. 216 otoscopes may be easily adapted for use with KLEEN-SPEC disposable specula, as shown.



Draw a fresh, new KLEEN-SPEC speculum from convenient push tube.



Press into place on permanent inner speculum and use.



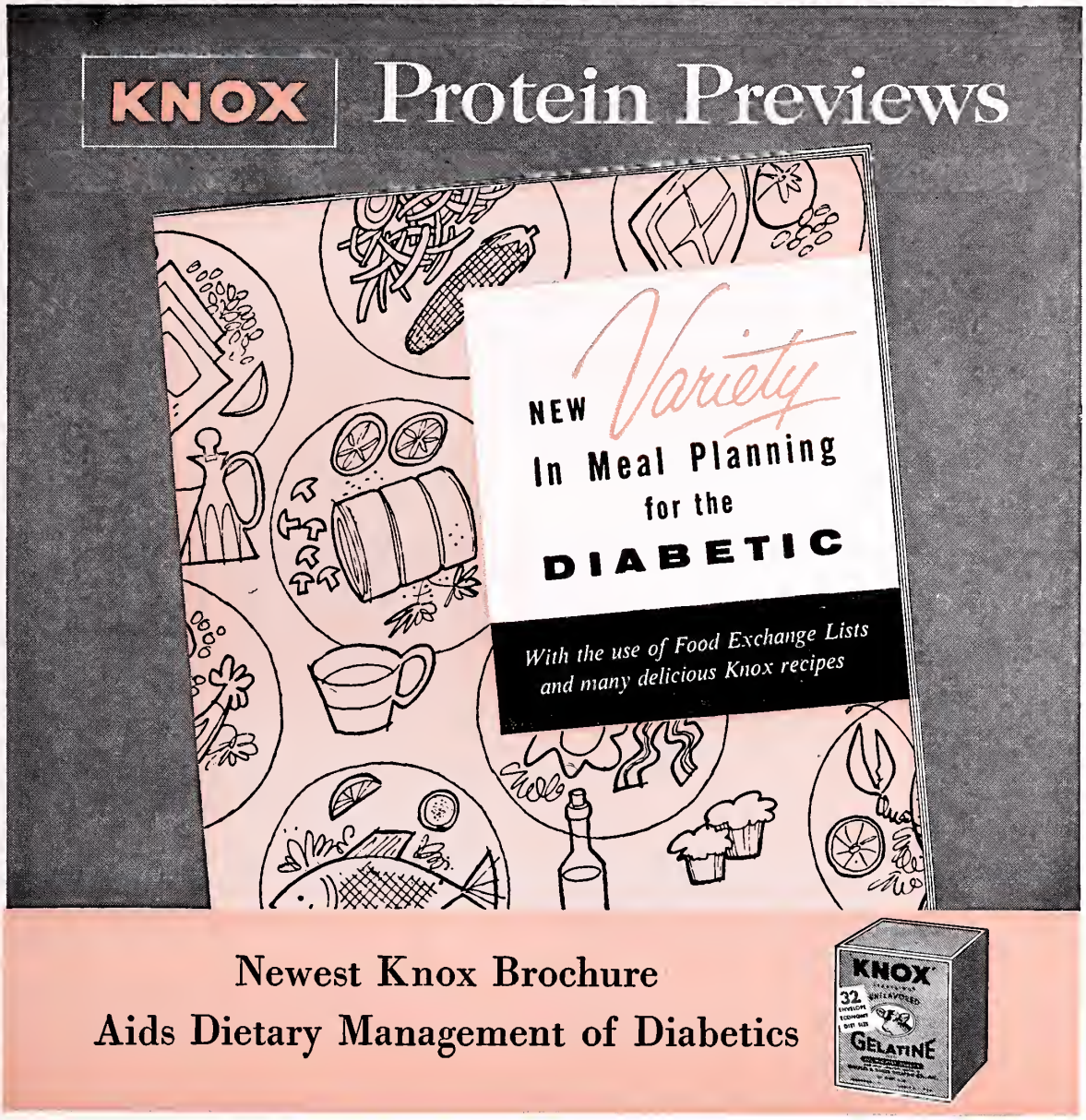
Remove used speculum by pulling tab and discard. The whole process takes less time than changing old style specula.

A major advance in instrument design by

WELCH ALLYN

VON HAMM-YOUNG COMPANY
P. O. Box 2630, Honolulu 3, Hawaii

KNOX Protein Previews



Newest Knox Brochure Aids Dietary Management of Diabetics

Although more than 50% of diabetics can be managed with proper diet, continued success is dependent upon proper motivation of patients. Determination to abide by dietary restrictions is also important for the diabetic being managed with insulin.

The new Knox booklet "New Variety in Meal Planning" has been prepared to help the physician enlist the patient's enthusiasm for dietary measures and to help maintain this enthusiasm. It explains the importance of diet to the diabetic, shows him how to use the newest dietary advance —Food Exchange Lists[1]—and then describes how to provide tasty variety with 14 pages of tested, diabetic recipes.

"New Variety in Meal Planning" makes no attempt to prescribe a system of treatment. It shows how the recipes described may be used to good advantage in practically any system of diabetic management. If you would like a supply for your practice, use coupon below.

1. Developed by the U. S. Public Health Service assisted by committees of The American Diabetic Association, Inc. and The American Dietetic Association.

Knox Gelatine Company
Professional Service Department SJ-20
Johnstown, N. Y.

Please send me.....copies of the new Knox diabetic brochure describing the use of Food Exchange Lists.

YOUR NAME AND ADDRESS

NEW

For Pain-Free

of everyday

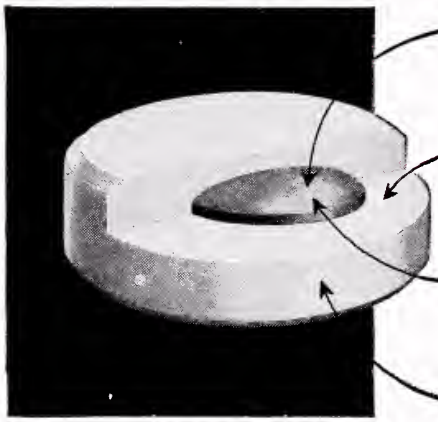
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combine:

THE PROPER FORMULA
PROPERLY FORMULATED



Physical separation of the steroid component from the aluminum hydroxide as provided by the Multiple Compressed Tablet construction assures full potency and stability of prednisolone.

PREDNISOLONE (*1 mg.*)

+

ASPIRIN (*0.3 Gm.*).....

+

ASCORBIC ACID (*50 mg.*

+

ANTACID (*0.2 Gm.*).....

*Early rheumatoid arthritis
Rheumatoid spondylitis
Osteoarthritis
Still's disease
Psoriatic arthritis
Bursitis
Synovitis
Tenosynovitis
Myositis
Fibrositis
Neuritis

Performance

activities

Patients



Compressed Tablets

TEMPOGEN®

..... for anti-inflammatory, anti-rheumatic benefits *at effective low dosage.*

..... for analgesia plus additional anti-rheumatic activity.

..... for anti-stress support that guards against adrenal ascorbic acid depletion.
(Ascorbic Acid present as 60 mg. Sodium Ascorbate.)

..... dried aluminum hydroxide gel minimizes the possibility of gastric distress.

DOSAGE: *1-4 TEMPOGEN Tablets t.i.d. or q.i.d. (TEMPOGEN Forte, 1 or 2 tablets t.i.d. or q.i.d.) for one or two weeks. Then lower by 1 tablet every four or five days to maintenance level.*

SUPPLIED: *TEMPOGEN and TEMPOGEN Forte —in bottles of 100 Multiple Compressed Tablets. (TEMPOGEN Forte provides 2 mg. of prednisolone.)*

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MERCK SHARP & DOHME
DIVISION OF MERCK & CO., INC.
PHILADELPHIA 1, PA.

HAWAII MEDICAL ASSOCIATION

(Continued from Page 206)

FEE SCHEDULE

Dr. Boyden then brought up the last matter of the agenda and read Dr. Felix's letter, to-wit:

October 4, 1956

Dr. Webster Boyden, President
Hawaii Medical Assaciation
510 S. Beretania Street
Hanalulu, Hawaii

Dear Dr. Bayden:

The membership af the Honolulu County Medical Saciety has met and considered the request from the council of the Hawaii Medical Associatian regarding the Dependents' Medical Care Fee Schedule.

The follawing report from our Fee Adjustment Committee, and approved by our Medical Care Plans Committee, was adopted in toto at a special meeting held last night:

After reviewing the farmat af this schedule, it wos found thot it was practically a capy af the Califarnia Relative Value Schedule. Inasmuch as aur own fee survey will not be completed by the deadline set by the Deportment af Defense, and due to the three years of comprehensive study that went inta the Califarnia Relative Value Schedule, the Fee Adjustment Committee recommends thot the Hawaii Medical Assaciation adopt the latter schedule for the Dependents' Medical Care Fee Schedule.

The Committee further recommends that the following bose fees and canversion factors be adapted:

Medical Services:	
Hospital Visit	$4.00
Canversion factor	400%
Surgery:	
Appendectamy	$150.00
Canversion factor	428%
Radialagy:	
Chest, Single P.A.	$10.00
Conversion factar	500%
Pathology:	
Blaad, Complete Count	$5.00
Canversian factor	500%

The follawing item is listed under Medical Services in the Dependents' Medical Care Schedule and is not in the Relative Value Schedule:

Pralanged hospitalization—mare than one manth—per month (not to apply ta first month).

The Committee recammends 22.5 Units ($90.00) for this item.

Sincerely yaurs,
J. M. FELIX, M.D.
President

Dr. Fronk moved that we accept the fee schedule as outlined.

Dr. Ing seconded the motion and it was passed unanimously.

Dr. Boyden said that we will be asked to send a representative to Washington to negotiate a contract for the fee schedule and asked if there were any objections to giving him that authority.

Dr. Felix wondered if it might be appropriate for our Delegate or Alternate to be considered.

Dr. Boyden said the reason for his suggesting himself was that we don't know when this meeting will take place and we do know there is a mid-season AMA convention in Seattle the latter part of November.

Dr. Yee said he was the alternate delegate but when it comes to matters of business negotiations, he didn't feel he would like to go because he was likely to get all balled up in figures. The person appointed should know about business and the workings of the office. He suggested Mr. Kennedy.

Dr. Burden moved that the president, Dr. Boyden, represent us in this meeting and act for the HMA.

Dr. Rockett seconded the motion and it was passed unanimously.

Dr. Fronk moved that our delegate contact a man on the Medicare task force committee and invite him to come to the Islands and explain the whole thing to us.

Dr. Yee seconded the motion and it was passed unanimously.

It was again pointed out that the California Medical Association had very generously given us free of charge the 500 copies of their relative fee schedule which were mailed to the members.

Dr. Ing moved that they be thanked again in the name of the House of Delegates.

Dr. Quisenberry seconded the motion and it was passed unanimously. The meeting was adjourned at 10:35 p.m.

SATORU NISHIJIMA, M.D.
Secretary

MEDICAL LIBRARY

(Continued from page 162)

Pediatrics

Dunham, E. C. *Premature infants.* 2nd ed. rev. c1955. (gift of publisher)

Surgery

American College of Surgeons *Surgical forum.* v.6. c1956. (gift of Dr. Brennecke)

Gillies, H. D. *Plastic surgery of the face.* 1920. (gift of Dr. Richert)

Hollinshead, W. H. *Anatomy for surgeons. The thorax, abdomen, and pelvis.* v.2. c1956. (gift of publisher)

Little, D. M. *Controlled hypotension in anesthesia and surgery.* c1956. (gift of publisher)

Tripler Army Hospital, Dept. of Surgery *Symposium on trauma.* 1956. (gift of Tripler Army Hospital)

Walters, Waltman, ed. *Lewis' practice of surgery.* 12v. 1955. (gift of Dr. Batten)

Tropical Medicine

Littman, M. L. *Cryptococsis,* c1956. (gift of publisher)

Manson-Bahr, Sir Philip *History of the School of Tropical Medicine in London (1899-1949)* 1956. (gift of publisher)

Nichols, Lucius *Tropical nutrition and dietetics.* 3rd ed. 1951.

Urology

Dodson, A. I. *Synopsis of genitourinary diseases.* 6th ed. c1956. (gift of publisher)

Lewis, Bransford *Cystoscopy and urethroscopy for general practitioners.* c1915. (gift of Dr. R. O. Brown)

Miscellaneous

American College of Surgeons Directory—1956. (gift of American College of Surgeons)

American Medical Association *J.A.M.A. clinical abstracts of diagnosis and treatment.* c1956. (gift of publisher)

Armed Forces Medical Library Catalog, 1955. 1956.

Blakiston's new Gould medical dictionary. 2nd ed. c1956. (gift of publisher)

History of the Medical Department of the U. S. Navy in World War II. v.2-3. 1950-53. (gift of U. S. Navy)

Musselman, M. M. *Terramycin.* c1956. (gift of publisher)

Quarterly cumulative index medicus. v.55. Jan.-June 1954. c1956.

Regan, L. J. *Handbook of legal medicine.* c1956. (gift of publisher)

Stone, Abraham *The premarital consultation.* c1956. (gift of publisher)

Stones, H. H., ed. *Dental health.* n.d. (gift of publisher)



new

Sigmamycin*

OLEANDOMYCIN TETRACYCLINE

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a new maximum
in therapeutic
effectiveness

a new maximum
in protection
against
resistance

a new maximum
in safety and
toleration

multi-spectrum
synergistically
strengthened...

for
your
entire



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OLEANDOMYCIN TETRACYCLINE



mycin*

a new certainty

in antibiotic therapy, particularly for the 90% of patients treated at home and in the office

Superior contral of infectious diseases thraugh superiar control of the changing microbial population is naw available in a new formulatian of tetracycline, autstanding broad-spectrum antibiatic, with oleandamycin, Pfizer-discavered new antimicrobial agent which controls resistant strains. The synergistic cambinatian now brings to antibiotic therapy: (1) a new fuller antimicrobial spectrum which includes even "resistant" staphylocacci; (2) new superiar pratection against emergence af new resistant strains; (3) new superior safety and toleration.

*TRADEMARK

Pfizer

superior control of infectious disease through superior control of the changing microbial population

new

Sigmamycin*

OLEANDOMYCIN TETRACYCLINE

A synergistically strengthened multi-spectrum antibiotic

Sigmamycin is a new antibiatic formulation praviding: (1) the unsurpassed broad-spectrum activity of tetracycline, the outstanding braad-spectrum antibiatic discavered and identified by Pfizer; (2) the actian of oleandomycin, the new antimicrabial agent which combats those strains, particularly amang staphylococci, naw resistant ta tetracycline and ather antibiatics.

Sigmamycin embadies a new cancept in the use af antibiatics, far with this new synergistically active preparatian, the develapment af refractary pathagens and their emergence as impartant saurces af superinfection are mare fully controlled.

New superior safety and toleration— Sigmamycin brings ta antibiatic therapy new superiar safety, new unexcelled toleration because: (1) tetracycline, an autstandingly well-tolerated antibiotic, is formulated with oleandamycin, also knawn to be remarkably free af adverse reactians; (2) the synergism between aleandamycin and tetracycline enhances antimicrobial patency.

Dosage: 1 ta 2 capsules q.i.d.

Supplied: Capsules, 250 mg. (aleandomycin 83 mg., tetracycline 167 mg.) Battles af 16 and 100.

*TRADEMARK

Pfizer

PFIZER LABORATORIES, *Division, Chas. Pfizer & Co., Inc.,* Brooklyn 6, N. Y.

BOOK REVIEWS

(*Continued from page 163*)

Ulcers of the Legs.

By P. Piulachs, M.D., 574 pp., illustrated, Price $15.50, Charles C. Thomas, 1956.

The volume is typical of the superior products the publishers are noted for from the standpoints of beauty of binding, legibility of type, and quality of reproduction of the illustrations. The author too obviously thinks in Spanish and lack of editing has resulted in a rather cumbersome style of expression. The dedication is to Dr. Rudolph Matas whose autobiography utilizes the first seven pages. An excellent introductory summary of the book follows; a rather unique literary hors d'oeuvre. The remainder of the work takes over 500 pages to cover the many aspects of the subject by a complete review of the pertinent literature with the author carefully confirming, refuting, and adding to present concepts with original observations and conclusions made by him and his co-workers. By virtue of the many abstracts and its exhaustive bibliography enhanced by the detailed index this book should prove invaluable as a source and reference work to all who are interested in caring for ulcers of the legs. A well-edited presentation of the author's thesis in a condensed form such as the "American Lecture" series would be most welcome.

ALEXANDER O. HAFF, M.D.

The Spine.

By Lee A. Hadley, M.D., 156 pp., illustrated, Price $6.50, Charles C. Thomas, 1956.

This monograph clearly and concisely presents the many developmental variations of the spine. It omits trauma except for the sequelae of whip-lash injuries. Evaluation of radiographs of the spine, particularly of the cervical region, will be enhanced greatly by a careful study of this book. Degenerative changes are also included. The text is a brief but adequate supplement to a veritable atlas of beautiful illustrations. All who are concerned with trauma of the spine will find this book of great value as a basis for ruling out non-traumatic conditions.

ALEXANDER O. HAFF, M.D.

The Treatment of Fractures.

By Lorenz Bohler, M.D., 1072 pp., illustrated, Price $24.50, Grune & Stratton, 1956 (Volume 1).

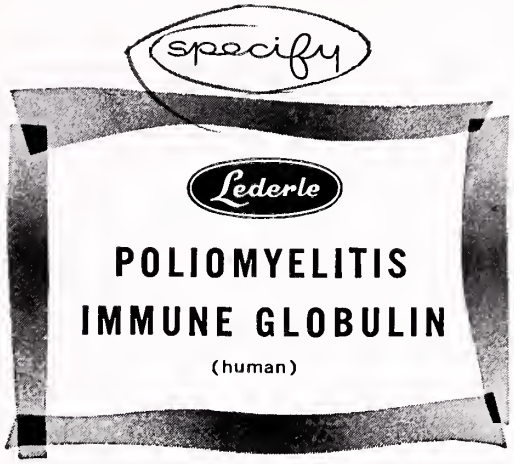
This large book represents the fifth English edition of the book which is based on the 12th-13th German edition. Volume I is divided into two parts: "General Considerations," local and systemic effects of trauma and general discussions of joint injuries, open fractures, and others; and "Special Parts," specific discussions of injuries to the axial skeleton and the upper extremity.

Good illustrations in varying body planes accompany good clinical and x-ray photographs to blend with the text into a thorough and useful discussion of trauma of the head, back, chest, abdomen, and upper limb. The detailed injury and treatment evaluations include an analysis of personal cases and conclude with long lists of factors predisposing to failure.

Dr. Bohler's great experience is frankly revealed and should provide valuable information for those interested and concerned with trauma. I believe the book is very good and recommend it highly.

GEORGE SUSAT, M.D.

(*Continued on page 220*)



For the modification of measles and the prevention or attenuation of infectious hepatitis and poliomyelitis.

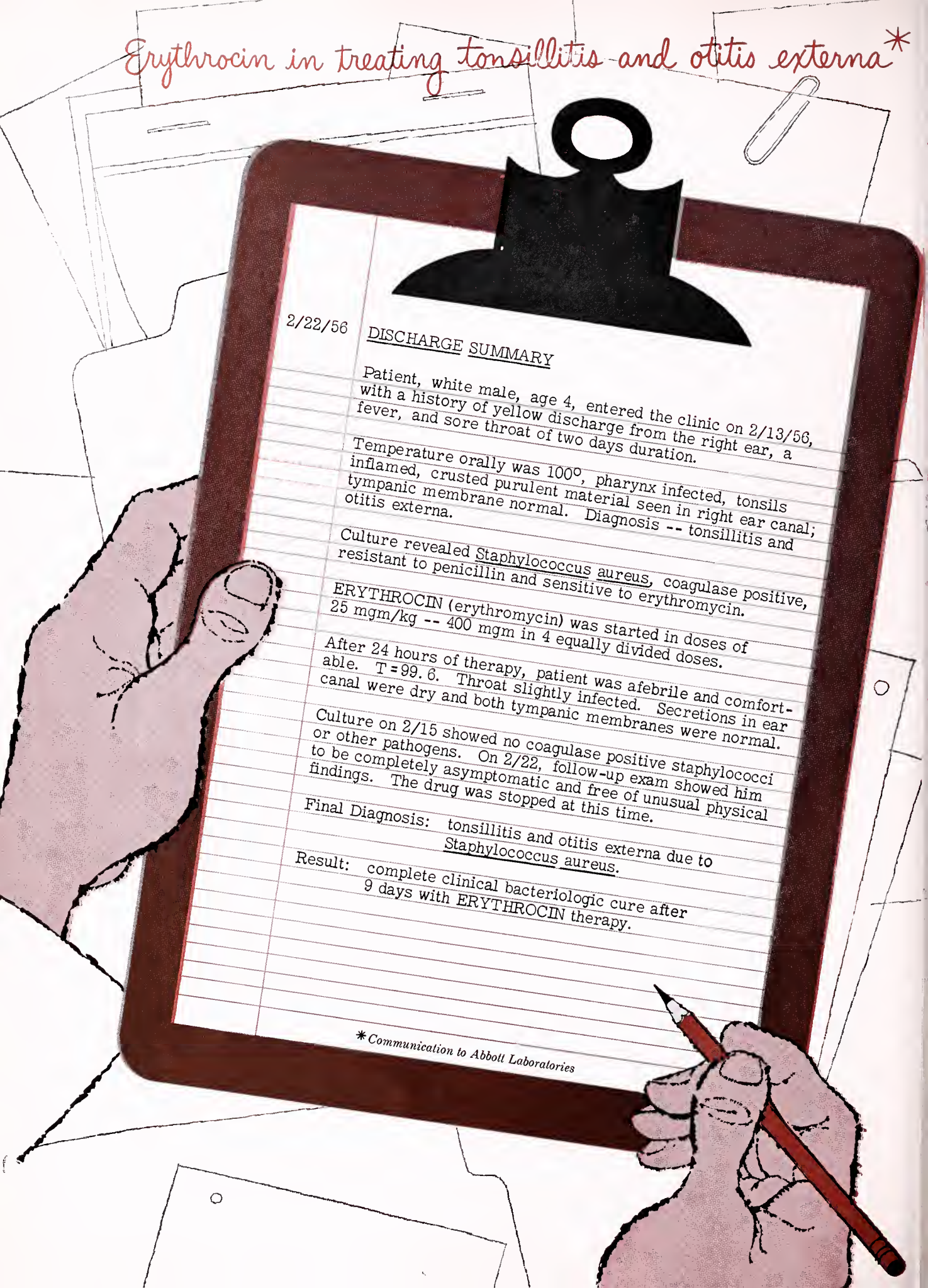
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DON'T GAMBLE
with your sight!

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 Exact filling of prescription
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Erythrocin in treating tonsillitis and otitis externa*



2/22/56 DISCHARGE SUMMARY

Patient, white male, age 4, entered the clinic on 2/13/56, with a history of yellow discharge from the right ear, a fever, and sore throat of two days duration.

Temperature orally was 100°, pharynx infected, tonsils inflamed, crusted purulent material seen in right ear canal; tympanic membrane normal. Diagnosis -- tonsillitis and otitis externa.

Culture revealed Staphylococcus aureus, coagulase positive, resistant to penicillin and sensitive to erythromycin.

ERYTHROCIN (erythromycin) was started in doses of 25 mgm/kg -- 400 mgm in 4 equally divided doses.

After 24 hours of therapy, patient was afebrile and comfortable. T = 99.6. Throat slightly infected. Secretions in ear canal were dry and both tympanic membranes were normal.

Culture on 2/15 showed no coagulase positive staphylococci or other pathogens. On 2/22, follow-up exam showed him to be completely asymptomatic and free of unusual physical findings. The drug was stopped at this time.

Final Diagnosis: tonsillitis and otitis externa due to Staphylococcus aureus.

Result: complete clinical bacteriologic cure after 9 days with ERYTHROCIN therapy.

*Communication to Abbott Laboratories

"clinical response good or excellent"

In one recent study, 18 patients with acute follicular tonsillitis and septic sore throat, were given erythromycin. Infecting organism was *Str. pyogenes*. The investigator stated, "*In all 18, the clinical response could be regarded as either good or excellent.*"[1]

This, of course, is only one of many reports showing the effectiveness of ERYTHROCIN against coccic infections. You'll get the same good results (nearly 100% in common, bacterial respiratory infections) when your prescription reads *Filmtab* ERYTHROCIN Stearate.

"toxicity lower in erythromycin-treated patients"

After a study of 208 patients treated with erythromycin (78), procaine penicillin (78) and a placebo (52), the investigator stated: ". . . *the incidence of toxicity* (compared to procaine penicillin) *was significantly lower in the erythromycin-treated patients.*"[1]

Actually, ERYTHROCIN stands on a remarkable record of safety. After four years, there's not a single report of a severe or fatal reaction attributable to erythromycin. Also, allergic reactions rarely occur. *Filmtab* ERYTHROCIN Stearate (100 and 250 mg.), is available in bottles of 25 and 100, at all pharmacies.

Abbott

® Filmtab—Film sealed tablets, Abbott; pat. applied for.

1. Herrell, W. E., Erythromycin, Antibiotics Monographs, No. 1, p. 29, New York, Medical Encyclopedia, Inc., 1955.
Idem p. 30.

filmtab®

Erythrocin® STEARATE

(Erythromycin Stearate, Abbott)

611243

BOOK REVIEWS

(Continued from page 217)

Premature Infants.

By Ethel C. Dunham, M.D., Second Edition, 459 pp., illustrated, Price $8.00, Paul B. Hoeber, Inc., 1955.

Dr. Dunham is a recognized authority in the field of prematurity. However, she has little gift for writing and even less for condensation. As a result, one is rapidly repelled from an attempt to read this book from cover to cover. As a reference book to look up specific phases of prematurity it is quite useful.

F. D. NANCE, M.D.

Observations in Krebiozen in the Management of Cancer.

By A. C. Ivy, M.D., 88 pp., illustrated, Price $2.50, Henry Regnery Company.

This most recent report is a scientific presentation on the palliative effects of Krebiozen in extensive or widespread malignancy in patients who have had the benefit of conventional methods of therapy or who have declined standard methods of therapy. A study of the evidence presented seems to indicate a definitely favorable but temporary palliative effect in certain widespread and seemingly "hopeless" cases of malignancy. It is important to note in the evaluation of the book that Krebiozen is presented only as a palliative in an experimental stage and not as a cure of malignancy.

The principle of attempting to develop specific immune or growth-inhibiting bodies by inoculation of concentrated extracts of malignant tissue into experimental mammals should be exploited to the fullest.

The development and use of Krebiozen is only a step in that direction but there seems to be a ray of hope in the hypothesis under which this substance was developed, such that further studies and experimentation should be encouraged and strenuously undertaken.

EDWARD V. AVAKIAN, M.D.

Electrocardiography—Fundamentals and Clinical Application.

By Louis Wolff, M.D., 342 pp., Price $7.00, W. B. Saunders Company, 1956 (2d Edition).

Dr. Wolff has completely revised his earlier text on Electrocardiography. He has incorporated some aspects of vector cardiography which can be applied effectively to the interpretation of the electrocardiogram. A section on the arrhythmias was a wise and valuable addition to the book. This is a concise and well written treatise on electrocardiography and would be a valuable addition to anyone's library, particularly those interested in cardiology.

J. L. BELL, M.D.

Synopsis of Genitourinary Diseases.

By Dodson and Hill (Austin I. Dodson, M.D., and J. Edward Hill, M.D.), 330 pp., illustrated, Price $4.85, C. V. Mosby Company, 1956 (6th Edition).

This synopsis has accomplished the purpose of presenting the essential facts of Urology to medical students and to serve also as a ready reference to the practitioner of medicine. It is well illustrated by pen and ink drawings and photographs to further enhance its value and usefulness.

EDMUND ING, M.D.

Clinical Laboratory Diagnosis.

By Samuel A. Levinson, M.D., and Robert P. MacFate, Ph.D., Fifth Edition, 1,246 pp., illustrated, Price $12.50, Lea & Febiger, 1956.

This text covers all aspects of laboratory analysis from the characteristics of normal saliva to the spermatozoa count. Approximately 80% of the book is devoted to the mechanics or technics of the performance of tests. The coverage is complete except for the latest advances in laboratory diagnosis such as protein-bound iodine and I-131 thyroid function tests. Laboratory tests are introduced by a brief clinical and physiological account of the disease to which they pertain but these short resumes are too brief to be of value to the clinician. Laboratory tests are interpreted but again the interpretation is exceedingly brief. The text is recommended as a reference source for office and hospital laboratories.

RAID CHAPPELL, M.D.

Internal Secretions of the Pancreas.

Vol. 9 of Ciba Foundation Colloquia on Endocrinology, 292 pp., illus., Price $7.00, Little, Brown & Co.

This highly technical book has little practical value for the clinician but is recommended as a reference to current fundamental research in the field of pancreatic endocrinology.

YOSHIE TAKAGI, M.D.

Meditations on Medicine and Medical Education.

By I. Snapper, M.D., 137 pp., Price $3.75, Grune & Stratton, 1956.

A scholarly American clinician unfolds the fascinating story of the origins of American medical teaching in medieval and Renaissance Europe in general and in the teaching hospitals of Holland particularly. He says that ". . . every generation of physicians has overestimated the progress made by medicine in its own time."

Fascinating, thought-provoking, permanently valuable, this is a book no one even casually interested in medical history should overlook.

HARRY L. ARNOLD, JR., M.D.

Dermatology.

By Donald M. Pillsbury, M.D., Walter B. Shelley, M.D., and Albert M. Kligman, M.D., 1331 pp., illus., Price $20.00, W. B. Saunders, 1956.

Three outstanding authors have joined together to refute the old saw that "textbooks are written to perpetuate error," and their efforts deserve the attention of reading doctors. A new format is presented which eliminates reference to many rare diseases of doubtful status and uses modern standardized terminology. The authors write with an obvious desire to improve the knowledge of the reader, who will find himself refreshed by the simplified language.

The chapters on basic principles of anatomy, physiology and pathology of the skin are the best yet produced anywhere. The illustrations appear to be all new and are well chosen. The printing is not on a par with that of most publishing houses and there is an unfortunate use of proprietary rather than generic names of drugs. The most impressive feature of the book is its up-to-date character. Although many subjects usually treated are eliminated, this is not a handbook but a complete textbook which will undoubtedly replace many old standards.

C. V. CAVER, M.D.

(Continued on page 223)

50 million crying babies changed to happy smiles



Since prehistoric fathers walked the cave floor with a squalling infant draped over one shoulder, human beings had been endlessly concerned with problems of artificial infant feeding . . . until a quarter of a century ago.

Then doctors discovered the most satisfactory all-round solution to the problem—evaporated milk.

So 50,000,000 babies grew up smiling instead of crying. Their stomachs didn't hurt. They could devote all their time to the important business of growing . . . and how they grew! (While 50,000,000 fathers got more rest.)

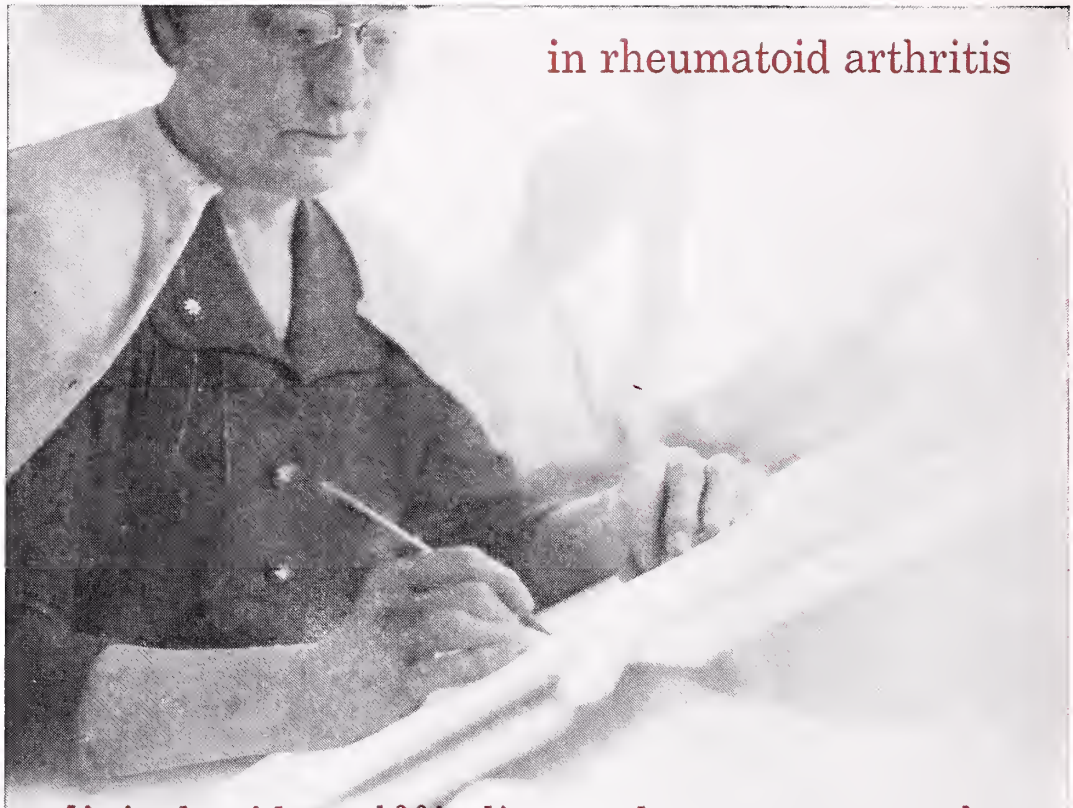
And evaporated milk is still unique in its combination of advantages for infant feeding . . . the higher protein sufficient to duplicate the growth effect of human milk . . . flexibility in carbohydrate prescription . . . maximum nutritional values . . .

at the lowest cost of any preparation for infant feeding available today.

PET EVAPORATED MILK
is the "going home" formula for more babies than any other form of milk.



PET MILK COMPANY • ARCADE BUILDING • ST. LOUIS 1, MISSOURI

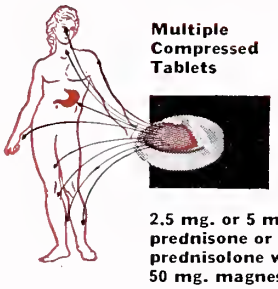


in rheumatoid arthritis

clinical evidence[1,2,3] indicates that to augment the therapeutic advantages of the "predni-steroids" antacids should be routinely co-administered to minimize gastric distress

ROUTINE CO-ADMINISTRATION MEANS

'Co-Hydeltra'
(Prednisolone Buffered)



Multiple Compressed Tablets

2.5 mg. or 5 mg. prednisone or prednisolone with 50 mg. magnesium trisilicate and 300 mg. aluminum hydroxide gel.

'Co-Deltra'
(Prednisone Buffered)

All the benefits of the "predni-steroids" plus positive antacid action to minimize gastric distress.

References: 1. Boland, E. W., *J.A.M.A.* 160:613 (February 25) 1956. 2. Margolis, H. M. *et al.*, *J.A.M.A.* 158:454 (June 11) 1955. 3. Bollet, A. J. *et al.*, *J.A.M.A.* 158:459 (June 11) 1955.

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MEDICAL ECONOMICS

(*Continued from page 161*)

private duty nursing care, and emergency care for dependents that space does not permit us to elaborate on. These items, along with other details, will be forthcoming after the Hawaii Medical Association negotiates a contract with an Executive Agent from the Department of Defense.

R. M. KENNEDY
Executive Secretary

BOOK REVIEWS

(*Continued from page 220*)

Anatomy for Surgeons.

By W. Henry Hollinshead, Ph.D (Vol. 2: The Thorax, Abdomen, and Pelvis), 934 pp., illustrated, Price $20.00, A Hoeber-Harper Book.

This is a large, bulky, nicely printed book full of an anatomist's attempt to capture a surgical conception with line drawings. The full-page, two-tone plates are almost entirely subsurface or deep sections of general topography and of little value to anyone. Many of the smaller illustrations are of greater value to a young surgeon than the texts long in use.

The reading material is brief, clear, and surgically inclined but some of it is already out of date.

Not recommended for purchase or for authority.

PAUL GEBAUER, M.D.

Studies in Topectomy.

Edited by Nolan D. C. Lewis, Carney Landis, H. E. King, 248 pp., illustrated, Price $6.75, Grune & Stratton.

This is a technical report on a very specialized subject of little interest to the average doctor.

JOHN J. LOWREY, M.D.

Dental Health.

Edited by Prof. H. H. Stones, M.D., 83 pp., illustrated, Price 10/4d, published by Dental Board of the United Kingdom.

This well-written book tells the dental story in a simple, concise and interesting fashion. The facts and illustrations are well presented. The reader who is not in the dental field will find the information readily understandable and not too technical. For me, the book served as an excellent review in basic fundamentals.

I would highly recommend this book to professional people interested in dental health. It would also be excellent reading for parents and teachers.

As a note of interest, this book was written in a foreign country by a British professor particularly for the British people. In the control of dental caries, Dr. Stones expresses similar views to those of Dr. Charles Sweet, Director of Dental Health Education with the Oakland Public School System and a leading dental educator in this country. Since these men are so widely separated, it is amazing that both advocate the same measures for the control of dental decay. They are reduction in sweets, good oral hygiene, regular dental visits and fluoridation of domestic water supplies.

CLARENCE T. LEE, D.D.S.

(*Continued on page 224*)



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BOOK REVIEWS

(*Continued from page 223*)

Diseases of the Chest.

By H. Corwin Hinshaw, Ph.D., M.D., and L. Henry Garland, M.B., B.Ch., 727 pp., illustrated, Price $15.00, W. B. Saunders Company, 1956.

Dr. Hinshaw and Dr. Garland have done an excellent job in summarizing the important history and findings to be found in various diseases of the lungs and chest. They have devoted more than the usual space to pulmonary emphysema and to the pulmonary and associated changes in collagen diseases. Recent knowledge concerning fungus diseases has also been included. Dr. Garland's knowledge of diagnostic roentgenology adds a great deal to the diagnostic aspects in the field of x-ray of the various pulmonary diseases.

The book is easily read and will be very useful as a reference and textbook in pulmonary diseases.

FREDERICK L. GILES, M.D.

The Premarital Consultation.

By Abraham Stone, M.D. and Lena Levine, M.D., 90 pp., illustrated, Price $3.00, Grune & Stratton.

The authors have produced a short, concise, and easily readable work which is subtitled, "A Manual for Physician." With no discourtesy intended, the manual in my opinion is more suited for lay readers. The simple anatomic diagrams and descriptions of the fundamentals of sex make this a valuable book to haul off your office shelf to illustrate one's premarital talk. With the exception of those of the Catholic faith I believe that the book would be well suited for patient reading material. The authors are to be congratulated on dwelling only lightly on sex in the postural sense and devoting much time to every day relationships of man and wife as pertains to the family unit. In the index is a chart of the legal phases of marriage in the various states.

FUGATE CARTY, M.D.

Also Received

Emotional Hazards in Animals and Man.

By Howard S. Liddell, Ph.D., 97 pages, Price $2.50, Charles C. Thomas, 1956.

Fascinating stuff, but primarily for psychologists and psychiatrists.

Of Water, Salt and Life.

Lakeside Laboratories, Inc., 72 pp., 31 plates, Price $7.50, Lakeside Laboratories, Inc., Milwaukee, Wis., 1956.

Twenty-nine colorful and imaginative diagrams with a brief explanatory text outlining normal fluid balance mechanisms and their commoner pathologic disturbances.

The Surgical Clinics of North America.

Lahey Clinic Number, June 1956, pp. 555-817, Figs. 157-271, W. B. Saunders Company.

A Lahey Clinic symposium on surgical technique.

Observations on Krebiozen in the Management of Cancer.

By A. C. Ivy, M.D., John F. Pick, M.D., and W. F. P. Phillips, M.D., 84 pp., illustrated, Price $2.50, Henry Regnery Company, 1956.

A resume of the use of Krebiozen as an adjunct for palliation in advanced cancer patients.

A Doctor's Marital Guide for Patients.

By Bernard R. Greenblat, M.D., 88 pp., illustrated, Price $1.50, Budlong Press (also a Catholic edition), 1956.

A useful booklet written for the layman which should be distributed by the family doctor to all newlyweds.

J.A.M.A. Clinical Abstracts of Diagnosis and Treatment.

Published with the Approval of the Board of Trustees, American Medical Association, 661 pp., Price $5.50, Grune & Stratton, 1956.

A handy reference for all physicians.

Epilepsy and the Law.

By Roscoe L. Barrow, and Howard D. Fabing, M.D., 177 pp., Price $5.50, A Hoeber-Harper Book, 1956.

This book should be read by all practitioners who have occasion to treat the epileptic patient.

Terramycin (Oxytetracycline)—Antibiotics Monographs No. 6.

By Merle M. Musselman, M.D., 144 pp., Price $4.00, Medical Encyclopedia, Inc., 1956.

A brief report on the pharmacology and the use of oxytetracycline.

Biochemistry of the Eye.

By Antoinette Pirie, M.A., Ph.D., and Ruth van Heyningen, M.A., D.Phil., 323 pp., illustrated, Price $7.00, Charles C. Thomas, 1956.

A valuable reference work by two Oxford students of the eye.

Lysergic Acid Diethylamide and Mescaline in Experimental Psychiatry.

Edited by Louis Cholden, M.D., 85 pp., illustrated, Price $3.60, Grune & Stratton, Inc., 1956.

A symposium on various aspects of modern pharmacology.

The Neurosurgical Alleviation of Parkinsonism.

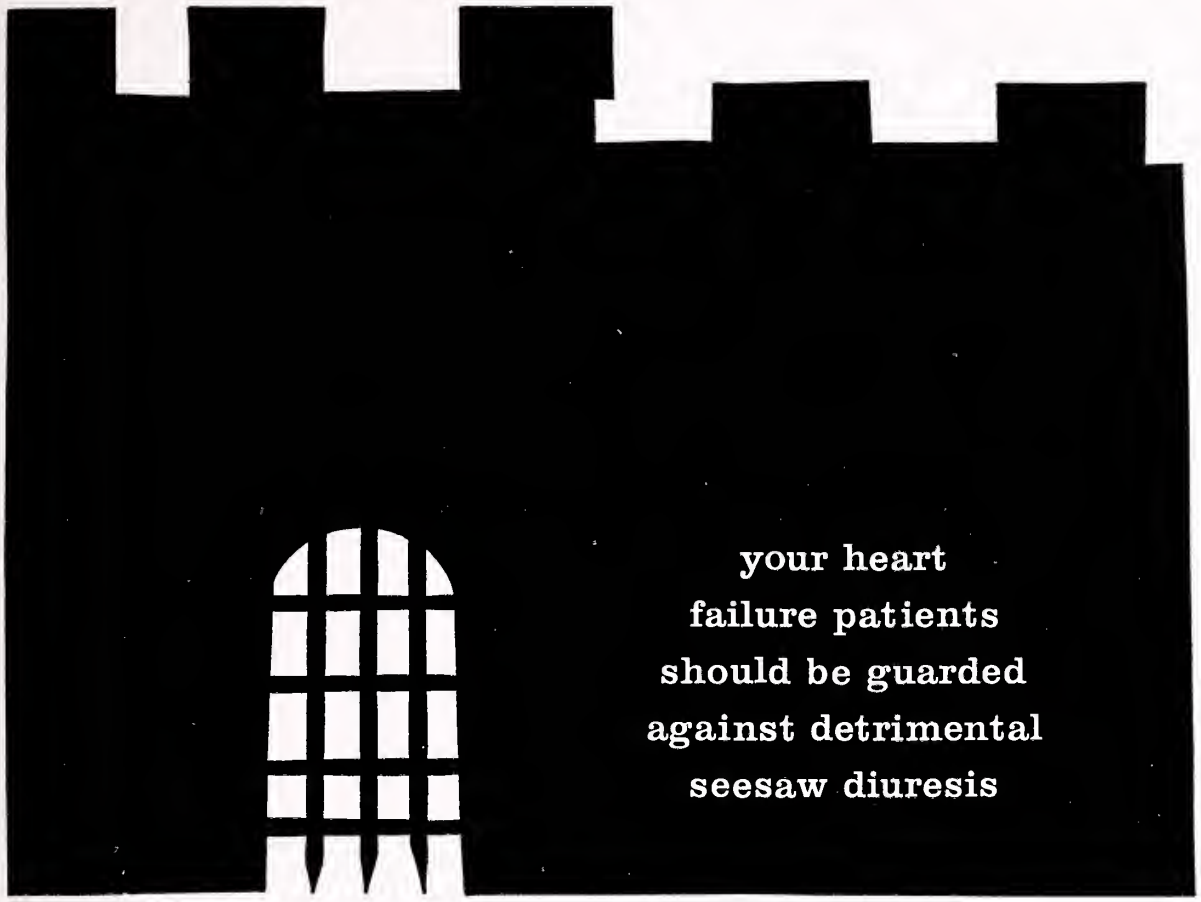
By Irving S. Cooper, M.D., 104 pp., illustrated, Price $8.50, Charles C. Thomas, 1956.

A beautifully illustrated monograph on a controversial subject which will be of great interest to neurosurgeons.

Today's Industrial Nurse and Her Job.

By Erna Barschak, Ph.D., 112 pp., Price $3.20, G. P. Putnam's Sons, 1956.

An excellent book for the nurse doing or contemplating industrial nursing.



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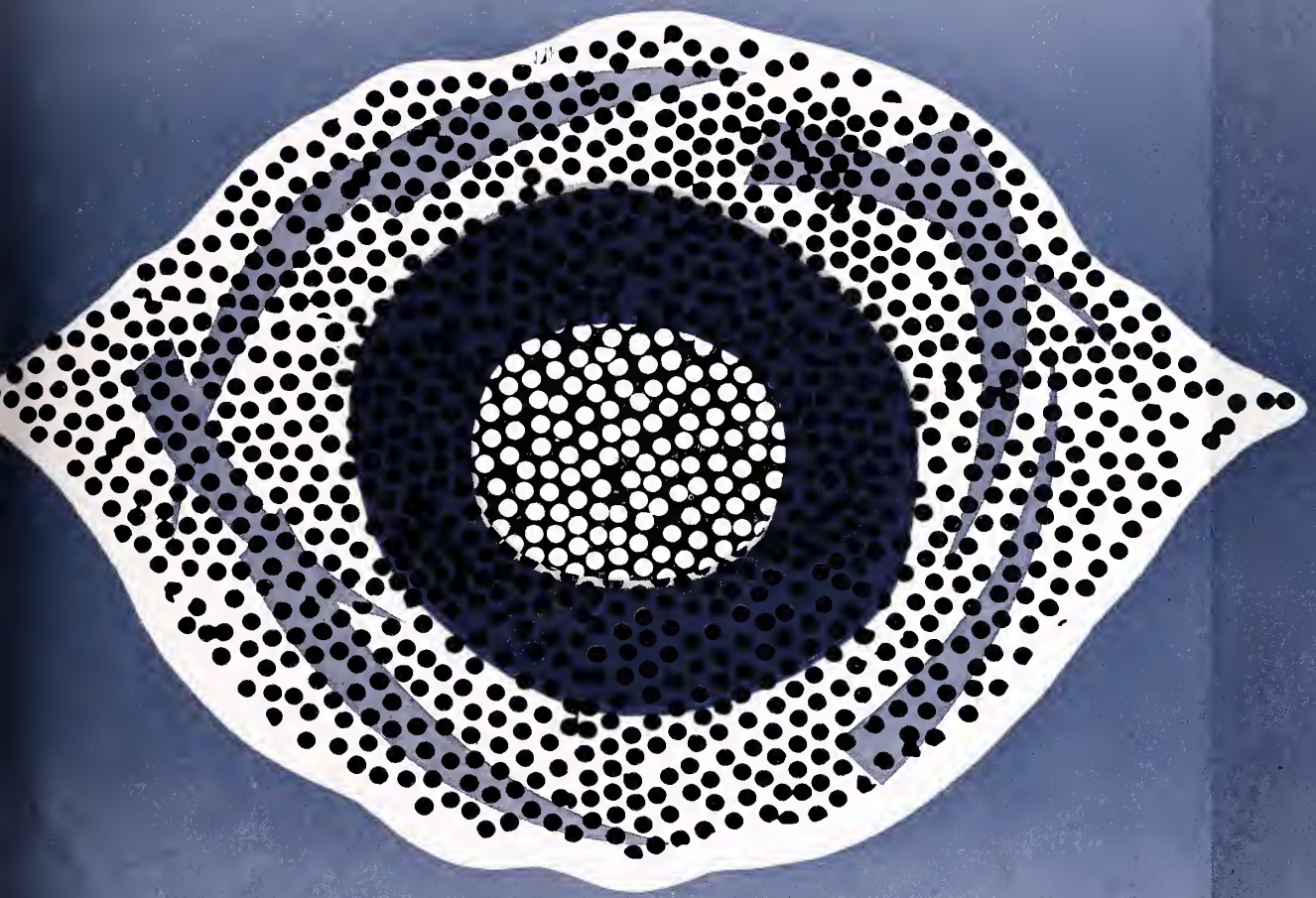
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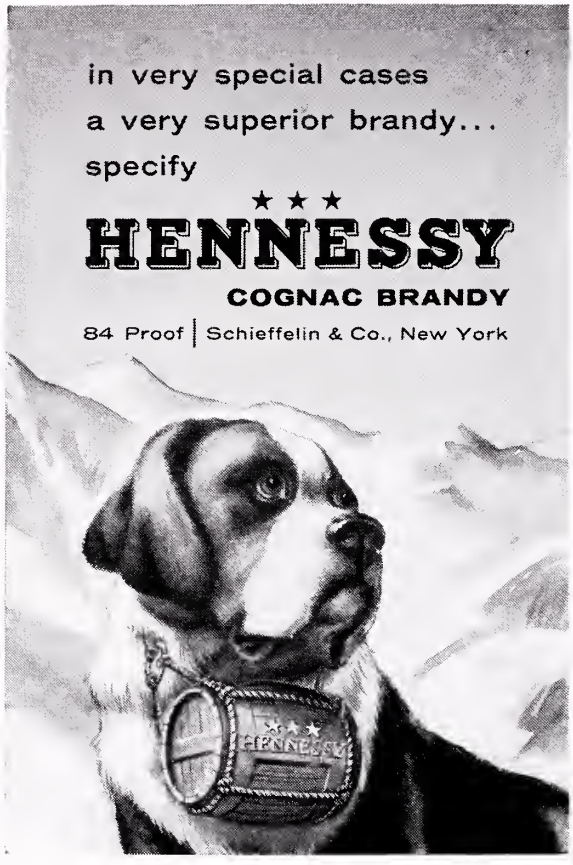
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CASE REPORT

(Continued from page 191)

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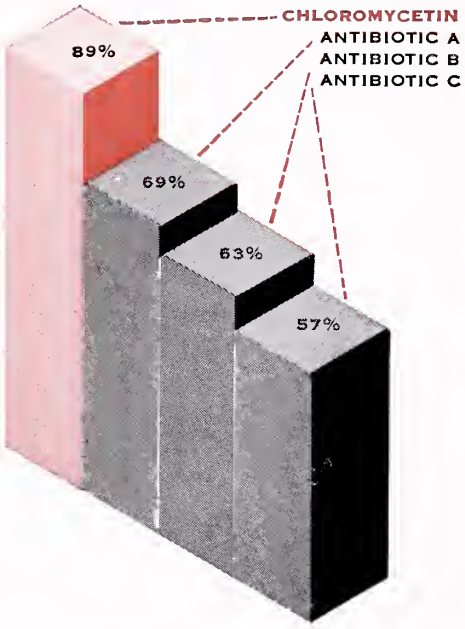
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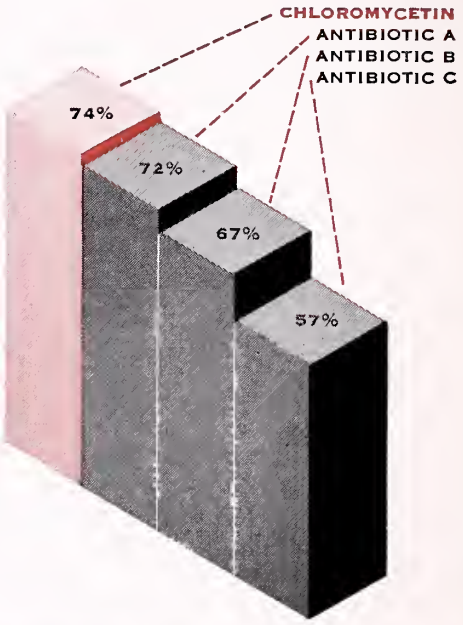
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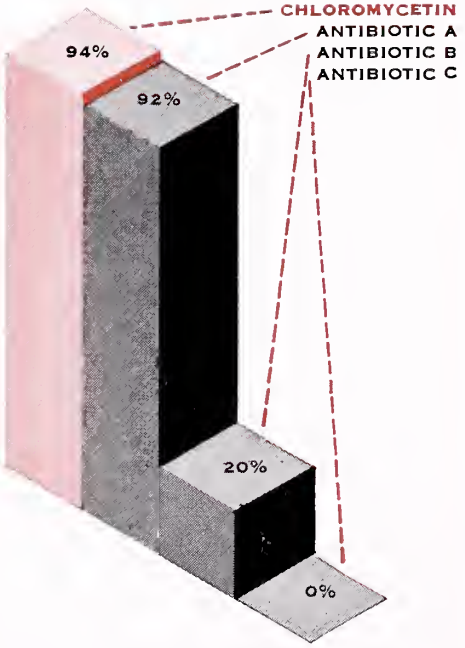
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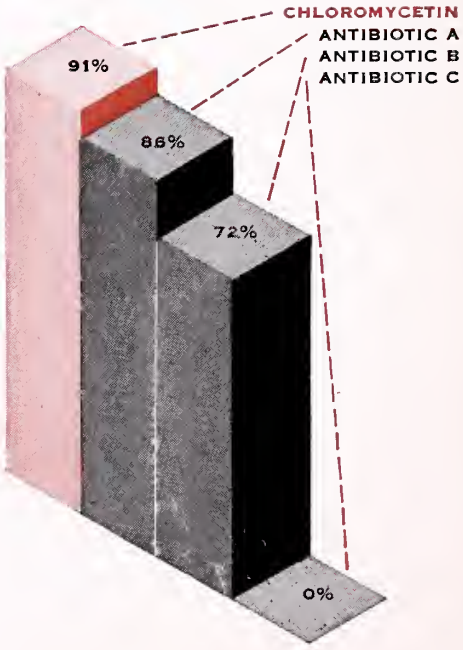
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*This graph is adapted from Altemeier, Culbertson, Sherman, Cole, Elstun, & Fultz.[1]

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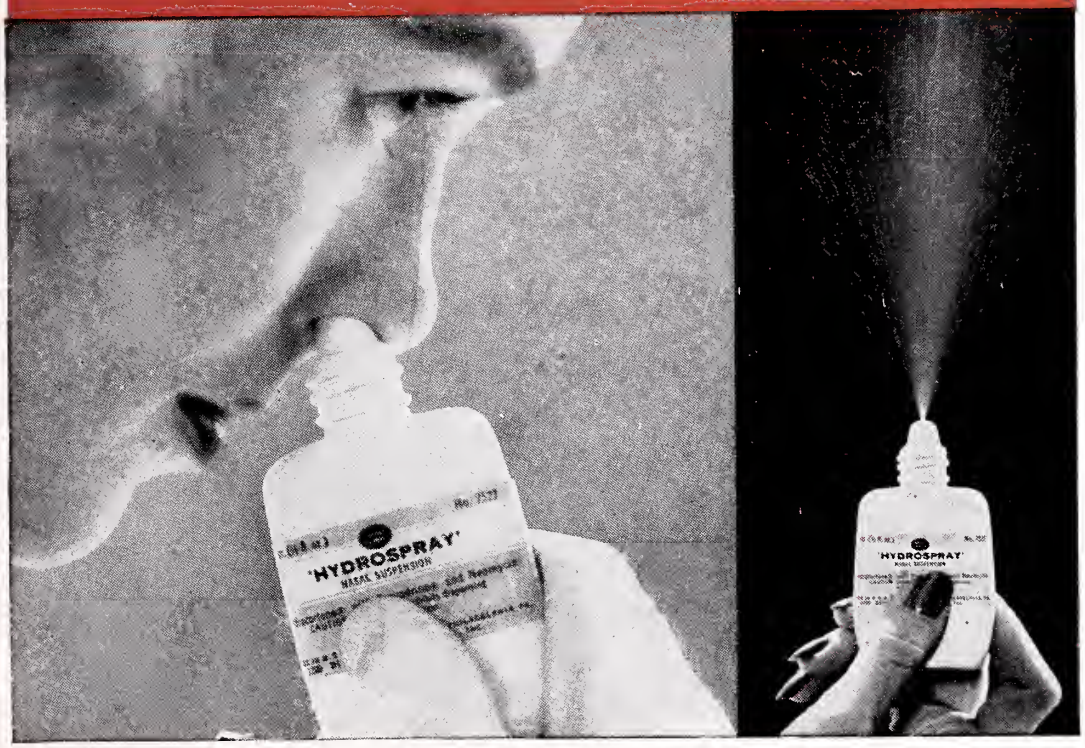
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Inter-Island Nurses' Bulletin

ROSIE CHANG, R.N., M.Litt., *Editor*

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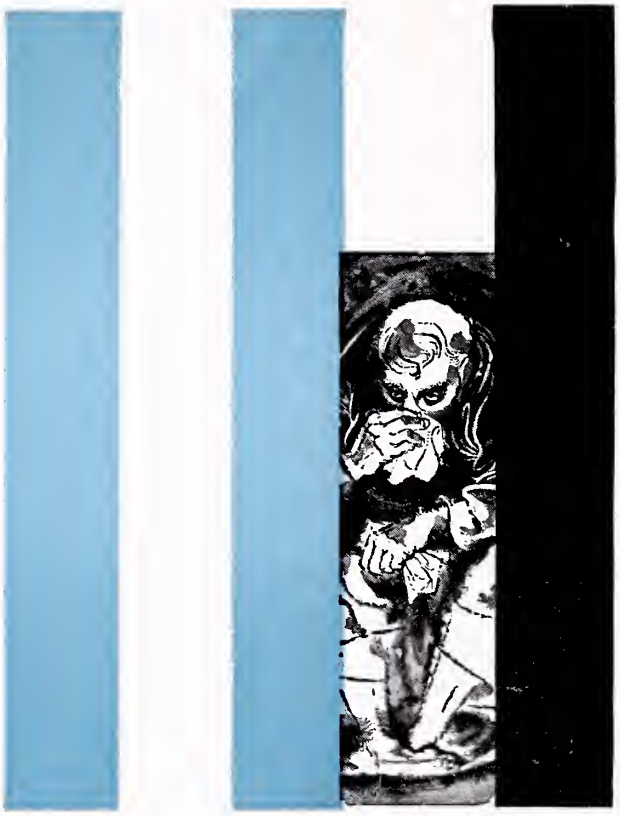
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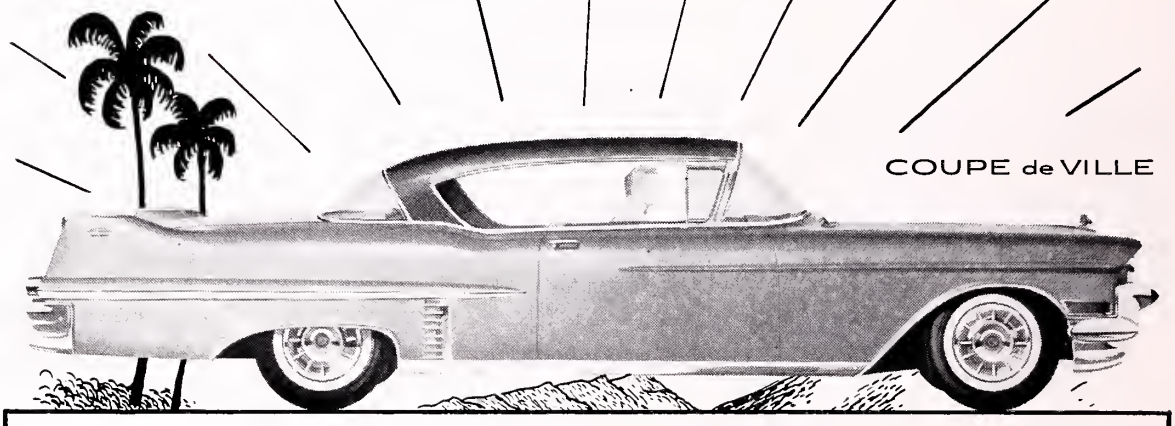
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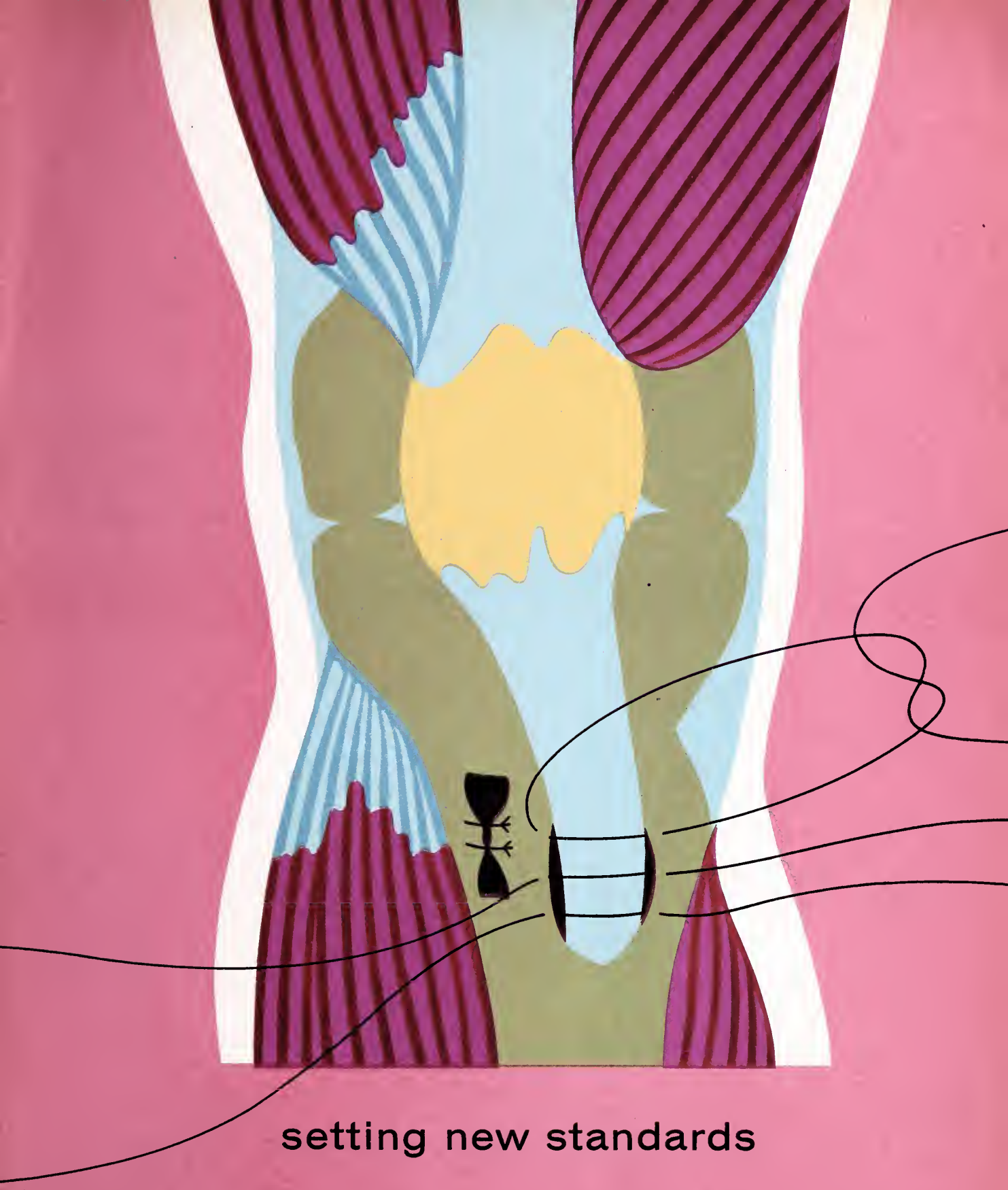
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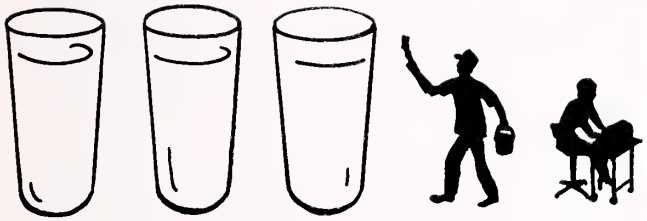
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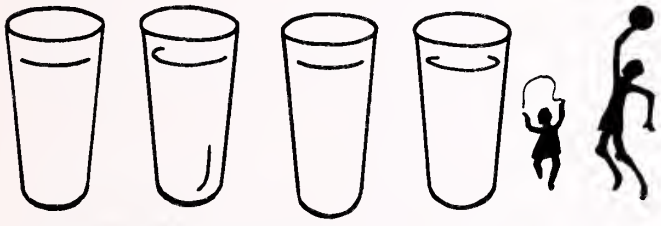
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MILK'S A MUST



3 glasses of fresh milk a day for grown-ups

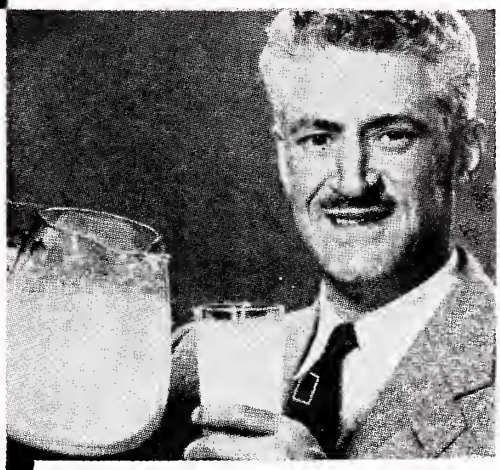


4 glasses of fresh milk a day for children

Increase Hawaii's fresh milk consumption today and you'll see a healthier people tomorrow!

Herrell DeGraff, Professor of Food Economics, Cornell University, said in effect:

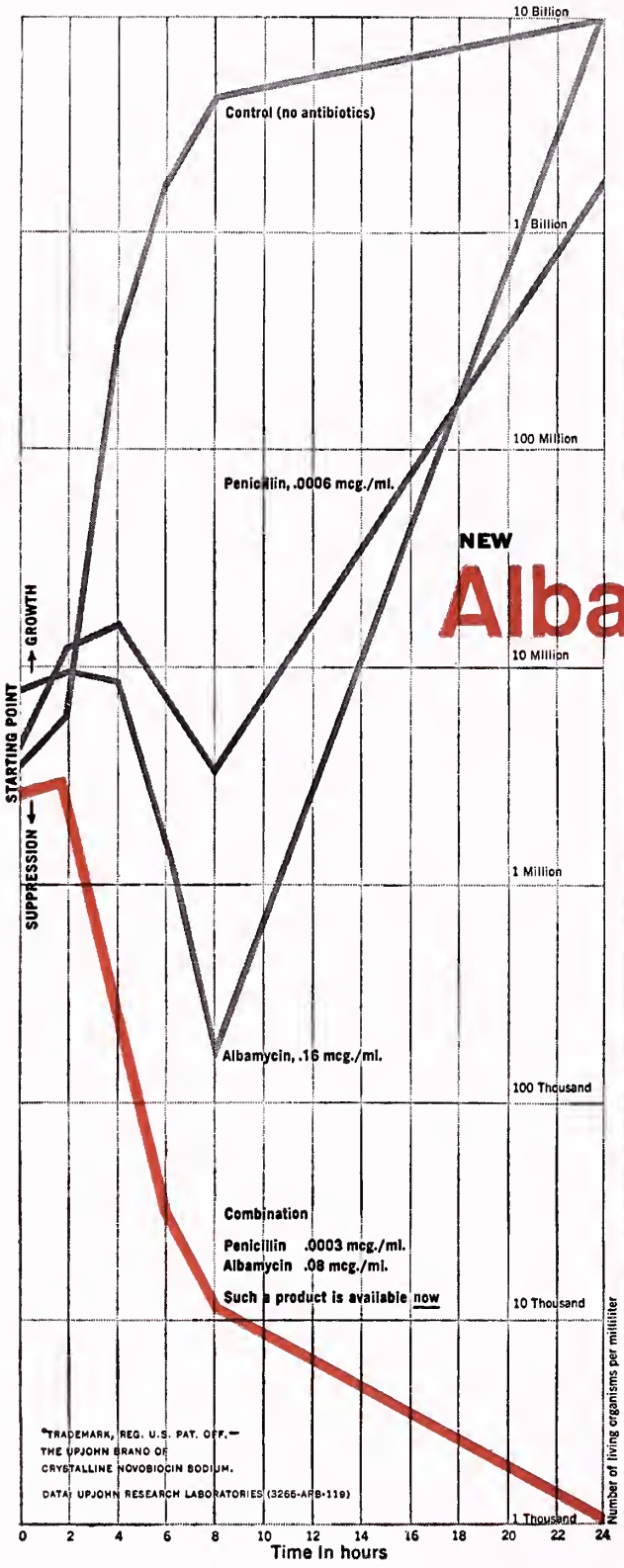
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average dosage only t.i.d.

antibiotic synergism

The three gray lines of this graph show the growth rate of a penicillin-sensitive strain of Staphylococcus (Micrococcus pyogenes, var. aureus) under 3 conditions:

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2. In the presence of subinhibitory concentration of penicillin
3. In the presence of subinhibitory concentration of Albamycin*

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Risk of enterocolitis: Because it has little or no effect on the predominant Gram-negative intestinal bacteria, and is highly effective against Staphylococci, there is virtually no danger of enterocolitis due to alteration in intestinal flora, or of other side effects such as perianal pruritus.

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3. Low sodium—very little fat—no cholesterol.

4. Sealed by nature in a dust-proof package.

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6. Can be easily digested by old folks as well as infants.

7. Can be readily eaten out of hand, in milk shakes, on cereals, or in salads.

8. Can be baked, broiled or fried.

9. Can be used as an ingredient product in breads, pies, cakes and desserts.

10. Useful in bland and low-residue diets.

11. Mildly laxative.

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18. Valuable in many allergy diets.

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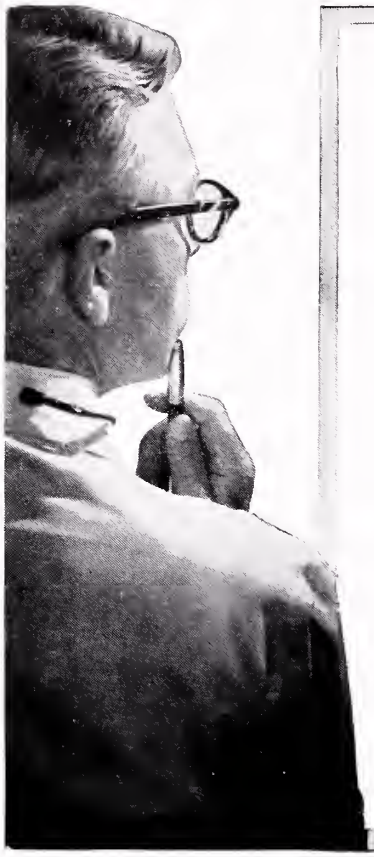
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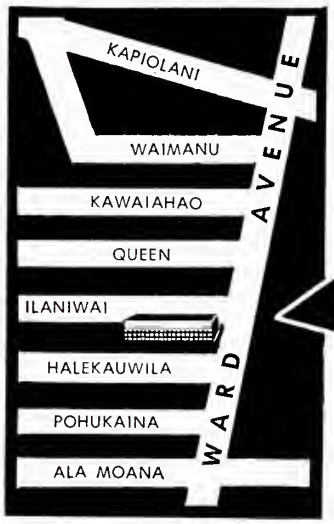
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Wine, however, the classic beverage of moderation, used as an aperitif, has been found to exert a profound stimulating effect on appetite and on the ability of both normal and anorexic patients to detect faint odors.[3] Goetzl and his co-workers have attributed this effect to such wine components as tannic acid, tartaric acid and acetic acid.[4, 5]

In actual clinical trials, Goetzl has reported the successful use of dry wines in increasing not merely the appetite, but also the food intake of patients suffering from anorexia. In one study on the appetite-stimulating action of wine, the average daily caloric intake in a substantial group of anorexic patients was increased from an average of 773 to 1228 calories.[6]

The above excerpts are taken from the brochure "Uses of Wine in Medical Practice" which describes the results of recent laboratory and clinical research on the medical attributes of wine. Herein are reported the latest findings on the value of wine as a stimulant to flagging appetite, as an aid to digestion, as a vasodilator, as a daytime and night-time sedative.

A copy of the brochure is available to you—at no expense—by writing to: Wine Advisory Board, 717 Market Street, San Francisco, California.



1. Margulies, N.R.; Irvin, D.L., and Goetzl, F.R.: Permanente Found. M. Bull. **8**:1 (Jan.) 1950.
2. Irvin, D.L.; Ahokas, A.J., and Goetzl, F.R.: Permanente Found. M. Bull. **8**:97 (Oct.) 1950.
3. Goetzl, F.R.: Permanente Found. M. Bull. **8**:72 (April) 1950.
4. Irvin, D.L., and Goetzl, F.R.: Permanente Found. M. Bull. **9**:119 (Oct.) 1951.
5. Irvin, D.L.; Durra, A., and Goetzl, F.R.: Am. J. Digest. Dis. **20**:17 (Jan.) 1953.
6. Goetzl, F.R.: A Note on the Possible Usefulness of Wine in the Management of Anorexia, unpublished.

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†Abrahamson, I. A., Jr., and Abrahamson, I. A., Sr.: Am. J. Ophth. *42*:482, 1956.

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Available *in specially coated tablets, pediatric suspension, drops, ointments, and I.M. and I.V. ampoules.*

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Medical Social Service–

DISCONTINUANCE OR REORGANIZATION?

MARGARET M. L. CATTON,* Honolulu

Medical Social Service in Hawaii's hospitals urgently needs reorganization under a community-wide advisory committee.

IN DECEMBER, 1955, Dr. Sumner Price, Medical Director and Administrator of The Queen's Hospital, addressed a letter to each of 103 members of the Visiting Staff, stating that "through resignations and lack of a qualified director the social service department [had] reached a state where it must either be discontinued or reorganized." The doctors were asked to express their opinions as to the value of social service to them individually, and for their ideas on how the department could be improved. Dr. Price's letter was prompted by a conference of a number of the Visiting Staff with Dr. Ruth Cooper, representing the Medical Social Work Section of the National Association of Social Workers. We shall come later to what brought Dr. Cooper to Honolulu.



MISS CATTON

Opinions of Doctors

Out of 103 doctors to whom letters were addressed, 26 replied. Without disclosing names, Dr. Price gave me a copy of the abstracts he had made of these replies. Half the doctors associated social service with a patient's ability, or inability, to pay for medical care. In this respect one doctor thought social service was the job of the City and County; another said that he seldom made use of it in private cases; one felt it could be discontinued as far as he was concerned; another said he never used it except for financial help for indigent or semi-indigent patients and doubted that a reorganization was worthwhile. The credit side of the replies include the following comments.

A complete reorganization indicated and sorely needed.

Definite value in investigations of homes, proper follow up, most anxious to see reorganization and operating along progressive lines.

No hospital can afford to be without a social service department, it is a community service, by all means retain.

Definite need, particularly in the field of finance and family quarrels, service invaluable.

A good medical social service department badly needed, don't believe it should concern itself with problems purely financial, preoccupation with this sort of problem responsible for comparative discredit into which this work has stepped.

Uncovers confidential details, not in favor of eliminating department.

Allowing for indifference to questionnaires in general, a total of 25 per cent replies to Dr. Price's communication might be tantamount to saying that a social service department is not important to a hospital; but, viewed in historical perspective, this would not hold. As compared to the centuries through which medicine has evolved to its present degree of proficiency, social service did not acquire the aspects of a profession until well within this century. It still has a long way to go before gaining the approval of the medical profession, to the extent where a social service department in a hospital would be considered essential.

Development of Social Casework

A fallacious idea continuing in the minds of many physicians, especially the older ones, is the idea that social service is only for the indigent. Historically this is understandable, for hospital social service began in England (1895) as a service for free patients and to prevent exploitation by those able to pay for medical care. For similar reasons, ten years later, it was introduced into the outpatient department of the Massachusetts General Hospital.

Social work has widened its horizon since those early days when workers, as apprentices, learned on the job and when their functions consisted

Received for publication August 15, 1956.

* Formerly Director of Medical Social Service, The Queen's Hospital, Kuakini Hospital, and Kauikeolani Children's Hospital.

chiefly in financial investigations relevant to hospitalization or the provision of the bare necessities of life. The broader view is due primarily to the academic education of staff, which is today a requirement of accredited agencies.

Many universities have schools of social work, some of them offering doctoral degrees in social work. Students who choose the medical social work sequence are being prepared to collaborate with the medical profession regarding the social and emotional components in illness and recovery.

At the same time there has come to be a more rational point of view among the medical profession, influenced largely by psychiatry and psychosomatic medicine. From an era in which their practice was predominantly influenced by the basic medical sciences and discoveries, doctors are now realizing that common to all human beings, irrespective of wealth, are personal and family problems that can be deep enough and serious enough to cause illness or to hinder environmental or psychological adjustment after it. Wealth, rather than poverty, may even be an adverse factor in some illnesses.

The elimination or modification of social and emotional problems in illness and recovery is a function of social casework. Though a dichotomy continues betwixt the two professions, committed alike to the treatment of man and his ills, there are indications of growing collaboration between them. An evidence of this is joint participation in medical education by committees representing the Association of American Medical Colleges and the Medical and Psychiatric Social Work Sections of the National Association of Social Workers. Faculties, too, of some medical schools include a medical social worker.

Two of the most common means of integrating the medical and social casework disciplines are the clinical clerkships in which social histories of patients are taken by students and the comprehensive home care services undertaken by students. In both these programs social service participates and is thereby integrated with the medical and other departments in a hospital in the education of medical students. Let us now return to Dr. Cooper and the reason for her visit to Honolulu.

A Hospital Institute

At a hospital institute held in Honolulu in 1954, during the Congress of the Pan-Pacific Surgical Association, a discussion on the essentials for hospital accreditation brought forth this question. "If now there is general agreement that social and psychological factors may have a bearing on diagnosis and treatment, why is a social service department not an essential in hospital accreditation?"[1]

Two visiting doctors with more than a passing interest in social casework—Dr. Robin C. Buerki, Administrator of Henry Ford Hospital in Detroit, and Dr. Arthur W. Allen, associated with the Massachusetts General Hospital—spoke positively in favor of it, at the same time stating that until there are enough qualified social workers, a social service department cannot be made an essential in hospital accreditation. These remarks were the answer to the question troubling the minds of the Medical Social Service Association of Hawaii.

Sponsoring Agencies

In the developmental years of hospital social service in England and America it was usual for extra-mural agencies to assume responsibility for the establishment and functioning of social service departments.

Honolulu followed suit when, thirty-odd years ago, an organization subsequently to become known as the Medical Social Service Association of Hawaii was given responsibility for the establishment and functioning of social service in three local hospitals.

By 1949 two of them wanted full control of their social service departments. The Association, therefore, planned to disincorporate, dividing its vested funds among the three hospitals. The administrators of two, wanting control of social service, refused to be bound by an incorporated purpose of the Association, namely, that the functions of medical social service must be in accordance with the standards of the American Association of Medical Social Workers.[2] Legally, this rejection of standards by the two hospitals made it impossible to give them a share of the financial assets of the Medical Social Service Association, nor could these all be given to the third hospital. To what use, then, could they be put?

As a result of the discussion at the above institute about the paucity of qualified social workers —as true in Hawaii as on the mainland—the Medical Social Service Association decided to expend its vested funds in furthering education for medical social service. Apropos of this decision an offer was made to the University of Hawaii and accepted by its Board of Regents.

The Medical Social Service Association then requested consultation with a representative of the Medical Social Work Section of the National Association of Social Workers. In response to this request Dr. Ruth Cooper came to Honolulu in

[1] Though social service is listed for evaluation by the Joint Commission on Accreditation of Hospitals, it is not mandatory in order for a hospital to be accredited.

[2] In October, 1955, the American Association of Medical Social Workers and the Association of Social Workers—an amalgamation of seven autonomous groups became the Medical Social Work Section of the National Association of Social Workers.

December, 1955. While here she conferred with the University of Hawaii School of Social Work, with hospital administrators, doctors, and others.

Recommendations

In the report of her survey Dr. Cooper made two recommendations: one, the establishment of a medical social work sequence at the School of Social Work; two, provision for an advisory committee to social service departments.

We had hoped that the first recommendation would have been implemented by now, but we still await the appointment of an acceptable faculty member to assume responsibility for it. When the program is initiated, hospitals with accredited social service departments will be asked to cooperate with the School of Social Work in providing opportunities for field practice under professional supervision. At the time of Dr. Cooper's visit The Queen's Hospital did not qualify in this respect.

As for the second recommendation—an advisory committee to social service—its importance is more clearly seen in the framework of functions listed by the American Association of Medical Social Workers in their Statement of Standards, adopted in 1949. These were approved by the American Hospital Association and are still in force.

1. Practice of social casework.
2. Participation in program planning and policy formulation within the medical institution.
3. Participation in the development of social and health programs in the community.
4. Participation in the educational program for professional personnel.
5. Social research.

The promulgators of these functions were aware of the uniqueness of social service in a hospital setting. It is the only one, among the many services in a hospital, which has both an extra- and an intra-mural focus. Social casework in behalf of a patient may begin before admission to hospital and continue after discharge from it, or as long as there is a medical-social problem. Not infrequently the practice of casework reveals the need of added community resources in the prevention and treatment of illness.

Dr. Cooper had read the history of the Medical Social Service Association and noted the intra- and extra-mural programs in which the workers had appropriately participated. She learned, too, of the institutions in the Territory which were established through the initiative of the Association, based on the practice of its workers. Dr. Cooper did not approve the dissolution of the Medical Social Service Association of Hawaii.

Influenced largely by Dr. Cooper's analysis of medical social service in Honolulu and her recommendations, the Medical Social Service Association, at its annual meeting in May, 1956, decided not to dissolve but to cooperate with the School of Social Work in furthering education for medical social service. It was also agreed at that meeting to seek the interest of a number of physicians to act in an advisory capacity to the Association and the School of Social Work, in promoting programs in medical social service.

Member Hospitals

Though the emphasis in this review is on The Queen's Hospital, passing mention will be made of the Kuakini and Kauikeolani Children's hospitals, in both of which social service was also established by the Medical Social Service Association. Similar to the course of events in Queen's, there has been a backward trend in the other two hospitals.

For some years after the withdrawal of the Association, in 1949, from its member hospitals, Queen's, which had a larger staff, did maintain standards; but by the time of Dr. Cooper's visit these were at an all time low. Mr. Kenji Goto, Administrator of Kuakini Hospital, had made professional education a minimum qualification but when the social worker engaged originally through the Medical Social Service Association resigned, Mr. Goto did not succeed in finding a qualified successor until August, 1956. The social worker at the Children's Hospital is not professionally educated for the position.

There is no better teacher than experience. Judging by the years when medical social work, under the aegis of the Medical Social Service Association, was in accordance with high standards, and by the disintegration of these following the withdrawal of the Association from its member hospitals, the importance of a community-based advisory organization is clearly seen. This is not to forget that the administrator of a hospital has responsibility for the functioning of social service no less than he has for all other departments, but a glance above at the approved functions of medical social service signifies that there are too many ramifications in them for one point of view.[3]

A community-based group would not be peculiar to Honolulu. In their Statement of Standards, the Medical Social Work Section of the National Association of Social Workers recommends an advisory committee "made up of interested professional and lay persons which would study the work of the department within and outside the hospital and would act as an advisory

[3] For some years before its withdrawal, the Medical Social Service Association of Hawaii included the administrators of its member hospitals on its executive committee.

committee in planning for current and future programs. Interpretation to the community regarding the work of the department and the hospital would also be a responsibility of such a group."

Summary and Conclusion

Dr. Price was in a quandary about the continuance or reorganization of the social service department in The Queen's Hospital. Toward its solution he sought opinions from the Visiting Staff. Judging by the poor response he got, one might think a social service department in a hospital is not very important.

In the light, however, of historical development and inferences drawn from current education and practice, both in medicine and in social casework, we have reason to believe that collaboration between the two disciplines is increasingly being established in medical schools and teaching hospitals. In these hospitals social service is integrated with other departments in the education of medical students.

We saw that the best means of implementing the approved functions of medical social service is by the support of a community-based advisory committee. We also saw that largely due to the withdrawal of the Medical Social Service Association of Hawaii, acting in this capacity, there has been a breakdown in the standards of medical social service in the hospitals once affiliated with the Association.

The Queen's Hospital has not discontinued social service. In June, 1956, Mrs. Willa M. Breeland, a professionally qualified social worker, became its director. Reorganization, nevertheless, is needed; but no one person, however competent, can do this alone. It requires the consensus of varying points of view relevant to accepted programs in medical social service.

If the final outcome of Dr. Price's letter to the Visiting Staff of The Queen's Hospital is the appointment of an advisory committee to social service, a committee inclusive of hospital administrators, doctors, and other interested persons, acting not only for Queen's, but for all hospitals in which there are, or should be social service departments the result would be a raising of standards, in both medical practice and social service. This would come about through extended collaboration between doctors and social workers, regarding the environmental and psychological components in illness and recovery.

Collaboration of this sort would make for professional contentment among social workers and there would be fewer resignations. One may assume, too, that under these circumstances another questionnaire addressed to the Visiting Staff of The Queen's Hospital would bring a much larger response than the first one did, in favor of a social service department.

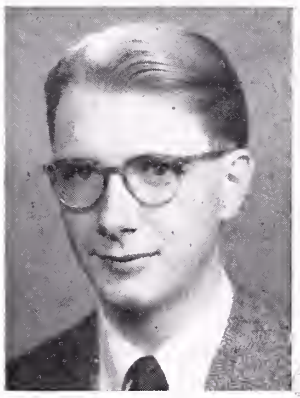
2226 University Avenue

SOCIAL SERVICE
Its Place in Medical Practice

L. G. STUHLER, M.D., Honolulu

A recent medical graduate tells of the importance and effectiveness of Social Service as he saw it during his undergraduate and postgraduate days of medical training.

A RECENT poll conducted in one of the Territory's largest hospitals demonstrated that the majority of physicians voting were opposed to a continuance of the hospital's Social Service program. Thus by a negative vote, a long established medical service was placed in jeopardy.



DR. STUHLER

Why did this come about? Two answers seem possible: either the Social Service program has been inefficient, or too few physicians have utilized Social Service properly and to the fullest extent.

Concerning the first conclusion, the record of the past years reveals full well what major achievements Social Service has accomplished. Thus we are compelled to conclude that a valuable medical ally may be lost because it has not been properly appreciated and employed.

In my own medical school days my first contact with Social Service was during a clerkship as a junior medical student. A woman had been discharged from a sanatorium with arrested tuberculosis. She had been told that a moderate amount of rest was necessary, but that she could be em-

ployed in a clerical position involving minimal physical exertion. Her former employer was willing to allow her to work only mornings, yet this was unsatisfactory because she had two small children who needed supervision at home. Social Service was asked to see this patient and was able to provide help for this woman from a former patient who wanted something to occupy her lonely hours. In this case, two patients were benefited.

As in any large city, unwed mothers and their babies posed a social problem. Once the immediate postnatal period was ended, a physician's responsibilities were considered over. There still remained, however, the problems of the mothers and the babies. Here again, Social Service stepped in to help solve many of these problems. Homes were found for mothers and the babies; in some cases babies were adopted, in others placed in foundling or foster homes; and in rare instances, Social Service was able to provide situations in which both mother and child were kept together. This last solution was resorted to only after careful screening by Social Service of both the mother and the new environment.

Important as the above are, by far the most important work done by Social Service was in the field of psychiatry and psychosomatic medicine. During the intensive psychosomatic orientation given during the junior and senior years, it was ever evident what a tremendous role socio-environmental factors played in the development of mental as well as physical illness. After a formal presentation of case history and examination findings, a social worker would present the environmental factors in the background of the psychiatric case.

Without this invaluable help, there is no doubt in my mind that treatment and eventual recovery would have been seriously affected. Who but the social workers, with their special skills, could have obtained this information? A physician sitting in a room talking with relatives is in a totally different situation from a person visiting a patient's family in the home, and observing what actually constitutes reality for that patient. People tend to use their best manners when "visiting." Thus, a physician's office or a hospital ward are anything but representative of home situations.

Psychiatric cases were given special mention above. It is true that very few physicians other than psychiatrists treat seriously mentally disturbed patients. But what of that nagging case of neurodermatitis, the stubborn duodenal ulcer, and the persistent tension headache? Sedatives, antispasmodics, ataraxics—all are ineffective with a truly intolerable home situation.

An internship in a large city hospital brings one into contact with psychiatric, psychosomatic, and somatic problems in all stages. These patients all need help, some financial, some emotional, and some physical. A man out of work with his wife in the hospital needs help with the children. Social Service helps to find someone to do housework for a week, and that man is able to seek employment. Another man is dying of cancer; Social Service helps find employment for his wife. A woman who has been withdrawn from heroin and is recovered physically is given a position and helped with a temporary loan to get a new start in life. Again diligent psychiatric Social Service case work contributes to current cases, and possibly acts in a prophylactic way to prevent future cases, of mental illness.

Residency training in a large medical center overshadows all previous educational contacts. Here as before, Social Service works closely with the physician, for as education progresses, so do problems mount. Although diagnosis and treatment of patients is still the prime responsibility of the physician, the scope of treatment today includes more than just giving a handful of pills and the usual admonition that "everything will be all right." Treatment includes providing a healthy mental as well as physical environment.

The elderly parent who lives with a son or daughter, and is considered more a boarder than a part of the family, will usually be much healthier and happier with other people her own age, or with a companion. Here Social Service can help greatly, and their help should be utilized frequently in such cases. Geriatrists will have increased need of Social Service, as evidenced by recent trends.

As was true in other phases of education, all previously mentioned situations were encountered during residency training. In addition, certain legal situations such as financial help from county or state agencies required some counsel, which was offered by Social Service. Finally, the problem of how to depose a patient from a hospital bed was occasionally met. Social Service would look into the family situation, often asking a distant relative or friend to care for the patient. If none were found, Social Service would aid in placing the patient in a nursing home.

In summary, present day medical education at both undergraduate and postgraduate levels convinces one that Social Service is an extremely valuable friend and ally of the physician. It is a service that should grow and mature with medical science, further increasing the future value of medical care.

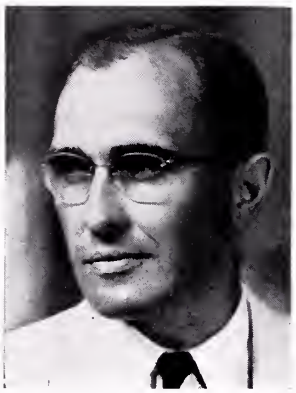
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OBJECTIVES IN SURGERY OF DUODENAL ULCER

CHARLES S. JUDD, JR., M.D.,* Honolulu

Vagotomy, partial gastrectomy, and gastrojejunostomy are advocated as a more physiologic approach to the surgical treatment of duodenal ulcer.

SINCE the first clear description of peptic ulcer by Cruveilhier of Paris in 1829, this disease has been a constant challenge to physicians. Differentiation between duodenal ulcer and gastric ulcer should be made. They occur in different gross locations, and in histologically different tissue. Palmer states that the fasting hydrochloric acid secretion in gastric ulcer is less than normal,[1] whereas in duodenal ulcer it is usually greatly increased. In 301 cases of marginal ulcer reported following subtotal gastrectomy, Walters found that the original disease was gastric ulcer in only two per cent of cases.[2] Because of the possibility of malignancy in an ulcerating lesion of the stomach, many physicians are now advocating early surgical treatment of these lesions rather than the conservative medical regimen usually afforded a duodenal ulcer.



DR. JUDD

The scope of this paper will be confined to duodenal ulcer. This disease, the precise etiology of which is unknown, affects the young, middle-aged, and old alike. It appears to be related to stress, as do the similar ulcers described by Curling[3] and Cushing[4] in severe burns and diseases of the nervous system respectively. The concept that hydrochloric acid is the greatest single known factor in the production and continuance of a duodenal ulcer is accepted in this paper as the basis for surgical treatment.

The usual treatment of duodenal ulcer is a conservative medical regimen, surgery being reserved for the complications (perforation, hemorrhage, and obstruction) or for those cases in which there is persistent intractable pain despite medical treatment. The very fact that there have developed so many methods of surgical treatment probably means that no one method represents an entirely satisfactory procedure. Simple excision of an ulcer and pyloroplasty were frequently unsatisfactory because of recurrence of the ulcer. Gastroenterostomy, with a sidetracking of the flow of food away from the ulcer, was heralded initially as a great advance in treatment, but later proved to result all too frequently in the formation of a marginal stomal ulcer. Subtotal gastrectomy developed popularity in recent years concomitantly with improvements in anesthesia, blood transfusions, and the development of the antimicrobial drugs. The reintroduction of vagotomy by Dragstedt in 1944 was another innovation. More recently the combination of vagotomy with a gastroenterostomy or gastrectomy has been in vogue.

The failures or complications of the various surgical procedures, aside from common surgical complications such as infection, atelectasis, and thromboembolic disease, resolve themselves into three main categories. First is marginal ulcer formation. Priestley has described an incidence of marginal ulcer development in 15 per cent of cases treated by gastroenterostomy.[5] Walters states it is 0.5 to 4 per cent following subtotal gastrectomy.[6]

Second, there is the "dumping syndrome," an entity usually characterized by weakness, sweating, abdominal discomfort, palpitation, and occasionally diarrhea, which is usually relieved by the patient's lying down. There are several theories as to the cause of these symptoms. One frequently cited is that there is rapid emptying of the gastric reservoir with rapid passage of food into the small intestine. Roberts has studied the blood volume of

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[4] Cushing, H.: Peptic Ulcers and the Interbrain. Surg., Gynec., and Obst. 55:1, 1932.

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[6] Walters, W., and Clagett, O. T.: Gastrojejunal Ulceration. Am. J. Surg. 46:83, 1939.

patients with these "dumping" symptoms who have had gastrectomies, and has found a marked decrease in the blood volume when hypertonic glucose is given by mouth.[7] He believes that a large gastrojejunal stoma results in the rapid passage of the glucose into the jejunum where it exerts an osmotic effect with resulting transudation of such large quantities of water and plasma into the lumen of the bowel that the blood volume diminishes and produces the symptoms of the "dumping syndrome."

Third, there is the failure to gain weight postoperatively. In this regard, Zollinger believes that a careful appraisal of the patient's physique must be made preoperatively, and that a proper operation must be adapted to the patient accordingly.[8] He emphasizes that an adequate gastric reservoir, or residual stomach, is especially important in obviating postoperative inability to gain weight. For the person of medium stature who has lost weight prior to surgery but who had achieved adequate nutrition, he combines vagotomy with a limited gastrectomy, leaving a substantial amount of stomach as a reservoir. For the very lean person who has difficulty normally in gaining weight, he advocates vagotomy combined with gastrojejunostomy, in an attempt to avoid depriving the patient of his much needed stomach.

A review of gastric physiology should enable us to formulate a rational therapeutic approach in selecting the correct operation for duodenal ulcer. Pavlov's studies in dogs established the concept of the cephalic or psychic phase of gastric secretion, in which the presence of food in the mouth or the sight or smell of food results in the secretion of hydrochloric acid by the parietal cells of the glands of the body and fundus of the stomach, stimuli being mediated by the vagus nerves. The gastric phase of secretion is best explained perhaps by the theory of Edkins, in which a hormone, gastrin, is secreted by cells in the antrum as a result of stimulation by the presence of meat extractives or products of protein digestion in that part of the stomach. This hormone, a histamine-like substance, in turn passes via the blood stream to the hydrochloric acid-secreting glands. A third phase of gastric secretion, the intestinal phase, results from another endocrine mechanism due to stimulation by food in the intestine. According to Best and Taylor, the cephalic and gastric phases each account for 45 per cent of the acid secretion in the stomach, and the intestinal phase for 10 per cent.[9]

If vagotomy will thus eliminate 45 per cent of the hydrochloric acid secretion in the stomach, it seems logical to embrace this procedure, provided the complications of vagotomy do not outweigh its effectiveness. By the same token, if removing the antrum or distal portion of the stomach, the site of origin of the gastrin, will eliminate another 45 per cent of hydrochloric acid secretion, it seems logical to use this procedure, along with vagotomy, to achieve the most effective antacid result. In summarizing his failures in cases where he used vagotomy alone, Dragstedt felt that stasis of food in the antrum stimulated the secretion of gastric juice of humoral origin.[10] Partial gastrectomy in addition to vagotomy would obviate this.

Colp and co-workers advocated subtotal gastrectomy combined with vagotomy in 1948.[11] Smithwick and others in 1951, and Edwards in 1953, established an operation of vagotomy combined with a conservative partial gastrectomy (40 to 50 per cent of the stomach).[12] More recently Zollinger has reported 194 cases treated in this manner,[8] and Stock 198 cases.[14] The results are very promising.

As regards technique, an infradiaphragmatic vagotomy is performed relatively easily through a standard longitudinal upper abdominal incision, which may be extended cephalad through costal cartilages or sternum if necessary. Vagectomy is perhaps a better term than vagotomy, inasmuch as an attempt is made actually to excise a segment of each vagus nerve 4-6 cm. in length. An attempt is also made to excise or sever any additional filamentous branches of the vagi. The cut ends are tied with fine silk. An estimated 40-50% of the distal portion of the stomach is removed, in an attempt to excise all of the antrum.

Although anatomical reconstruction of the gastrointestinal tract is probably accomplished best by the means of a gastroduodenostomy (Billroth I) and although this would seem a logical operation provided the ulcer-bearing tissue could be removed, there seems to be a lessening of enthusiasm for this procedure among a number of sur-

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geons.[15] Perhaps the failure of the Billroth I operation in a number of cases is due to the loss of the pylorus with its sphincter-like action and to the too-rapid passage of gastric contents into the duodenum with resulting increased stimulation of the intestinal phase of gastric secretion. A better choice of reconstruction, in my experience, is an antecolic isoperistaltic gastrojejunostomy, with the stoma the size of the diameter of the jejunum if possible. Fine interrupted sutures of silk are used throughout.

Zollinger's recent contributions regarding post-gastrectomy feeding emphasize the use of soft high caloric food on the second or third post-operative days and thereafter, rather than fluids.[8] He states that 340 grams of food will provide a patient with 1000 calories whereas it would take 600 cc. of fluid to provide the same number of calories. Sugar and milk appear to be poorly tolerated, and these are avoided in the diet given. Such foods as eggs, custards, potatoes, and tender meats are utilized for their concentrated food value and proteins. Zollinger also believes that seasoning is not detrimental and that it is of psychic benefit. He recommends extra fat in the post-gastrectomy diet, because fat absorption is diminished after gastrectomy and because fat delays gastric emptying time.

To summarize my objectives, I would advocate vagotomy to eliminate the cephalic phase of gastric secretion, and a resection of the distal 40 to 50 per cent of the stomach to eliminate the hormonal phase and still leave an adequate gastric reservoir.

Gastrojejunostomy is recommended as the technique of reconstruction. With adequate anesthesia and blood replacement, the operation should be done unhurriedly and with the utilization of Halstedian technique.

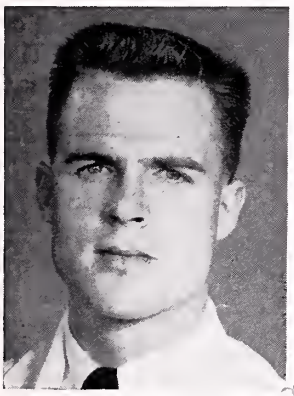
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BACTERIAL MENINGITIS IN INFANTS AND CHILDREN*

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Four pediatric residents and a pediatrician review 60 cases of bacterial meningitis and propose an effective treatment schedule, which is presented in detail.

SIXTY to eighty per cent of cases of non-tuberculous purulent meningitis in infants and children are due to only three bacteria—the meningococcus, the pneumococcus, and the influenzal bacillus.[1] Since the advent of the sulfonamides for the treatment of meningococcal meningitis, massive doses of penicillin for pneumococcal meningitis and the broad spectrum antibiotics for influenzal meningitis, the mortality and morbidity rates have sharply declined.[2] Further reduction will depend to a great extent on earlier diagnosis and more prompt administration of antimicrobials in optimal doses.[3]



DR. CAYLER

It is the purpose of this paper to review the treatment of all cases of non-tuberculous bacterial meningitis treated at the Kauikeolani Children's Hospital during the past five years (1950-1955); to compare the results of "early" treatment and "late" treatment; and to present a plan of treatment for meningitis with stress on those cases in which the causative organism is not identified.

Materials and Methods

Sixty cases of non-tuberculous purulent meningitis were reviewed. There were 23 cases of influenzal meningitis, six of pneumococcal, six of meningococcal, two of Salmonella, and one of staphylococcal, and 22 cases in which the causative organism was not identified. The 22 cases included in this latter group were all cases in which the diagnosis of purulent meningitis was strongly indicated in spite of the failure to obtain a positive spinal fluid culture. Seven of these cases had been treated at other hospitals prior to being transferred here.

The cases were divided into "early treatment" and "late treatment" groups on the basis of the condition of the patient at the time the diagnosis of meningitis was made. In the "early treatment" group, patients were selected on the basis of being in good condition at time of admission with symptoms for twenty-four hours, or less. It was sometimes hard to determine the exact time that signs of meningitis appeared in children with respiratory symptoms preceding their meningitis. The "late treatment" patients were those who were critically ill when the diagnosis was made. They were often in coma or semi-coma, convulsing and dehydrated.

Deciding whether the antimicrobial treatment was optimal or not was difficult because of the differences in the regimens of the many doctors (over twenty) involved. The following dosages were considered the *minimal* limits for being included in the "optimal antimicrobial therapy" group.

For H. influenzae—Broad spectrum antibiotic, 50-100 mg/kg/day.
For D. pneumoniae—Aqueous crystalline penicillin, 250,000 units/kg/day.
For N. meningitidis—Sulfonamide, 150 mg/kg/day.
For Salmonella and M. pyogenes—Antimicrobials, as indicated by sensitivity tests, in adequate dosage [4]
For unidentified—Broad spectrum antibiotic, 50-100 mg/kg/day.

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* From the Department of Pediatrics, Kauikeolani Children's Hospital.

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TABLE 1.—*Data on 60 Cases of Non-tuberculous Bacterial Meningitis.*

TYPE	NUMBER	EARLY THERAPY	OPTIMAL THERAPY	NUMBER UNDER 7 MOS.	AV. WBC COUNT	CEREBROSPINAL FLUID			DEATH	RESIDUA		SUBDURAL EFFUSION
						Cells	*Polys (%)*	*Sugar (mg%)*		*Major*	*Minor*	
Influenzal	23	11	14	8	18,000	12,000	85	15	5	3	2	3
Pneumococcal	6	1	0	2	18,500	2,000	85	15	2	1	0	1
Meningococcal	6	4	6	0	19,500	15,000	80	35	0	0	0	0
Undetermined	22	16	14	9	14,500	6,500	80	40	0	3	0	4
Other*	3	2	2	3	27,000	5,500	75	35	0	0	0	0
TOTAL	60	34	36	22	17,000	8,500	70	25	7	7	2	8

* 2 Salmonella and 1 staphylococcal.

Results

Incidence.—Non-tuberculous purulent meningitis accounted for 0.4 per cent of all hospital admissions. Thirty-eight of the patients were males and 22 females. There was no significant seasonal difference in incidence. Table 1 is a summary of the incidence of the various types of meningitis.

Age.—The average age of the entire group was 23 months with a range from four weeks to twelve years. Eighty-two per cent were under two years; 37 per cent were under seven months. As shown by Table 2, the patients under seven months had only a slightly increased incidence of death or residual brain damage but a greatly increased incidence of subdural effusions.

Race.—As might be expected in Honolulu, there was a broad racial distribution of the cases. Thirty were of mixed racial groups, eleven were Japanese, eight Caucasian, five Hawaiian, three Filipino and one each of Chinese, Korean and Portuguese ancestry.

Symptoms.—The presenting complaints were almost always fever, vomiting, and lethargy. Fifty per cent of the patients had associated upper respiratory infections. Fifty-five per cent had single or multiple convulsions during the course of their illness. Eighty-six per cent of the complications encountered in this study occurred in the patients who had convulsions.

Duration of Symptoms.—The duration of symptoms prior to the establishment of the diagnosis of meningitis ranged from twelve hours to twelve days. The average duration was a little over two days. The average for those patients who were critically ill was three days. The average was also three days for 17 patients who had received penicillin for fevers of undetermined origin or upper respiratory infections prior to admission. Seventy per cent of the deaths and 60 per cent of the complications encountered occurred in these 17 patients.

Physical Examination.—Thirty-two per cent of the cases did not have resistance to neck flexion. Fifty-eight per cent did not show a positive Brudzinski sign. The anterior fontanel was open in 27 cases. It was bulging at the time of admission in 16. There were no signs of meningeal irritation at the time of admission in ten patients. Cutaneous petechiae were noted in three of the six cases of meningococcal meningitis.

Laboratory.—Slightly more than one-third of the cases had a moderate to severe anemia. The white blood cell count at the time of admission was 8,000 or below in 23 per cent of the cases. The spinal fluid cell count at the initial puncture was below 1,000 in 22 per cent. The sugar was below 40 mg per cent in 77 per cent.

Positive spinal fluid smears were obtained on 39 patients. Three errors in identification were made. Twice influenza bacilli were mistaken for Gram-negative intracellular cocci, and the single case of staphylococcal meningitis was thought to be pneumococcal on the basis of the Gram stained smear.

Course.—The duration of fever after treatment was started ranged from one to thirty-seven days. The average was seven days. The average duration of hospitalization was twenty-eight days with a range of eight days to five and one-half months.

Antimicrobials.—The antimicrobial treatment for all 23 cases of influenzal meningitis consisted of a sulfonamide (usual dosage 200 mg/kg/day) and streptomycin (usual dosage 50 mg/kg/day). Fourteen also received one of the broad spectrum drugs in adequate dosage. None of the cases received intrathecal therapy. Eight were given rabbit antiserum.

The six cases of pneumococcal origin all received small doses of penicillin (50,000-100,000 units/kg/day) and a sulfonamide (usual dosage 200 mg/kg/day). One case received a single intrathecal injection of 20,000 units of penicillin. One other received chloramphenicol.

All six cases of meningococcal meningitis received a sulfonamide in adequate amounts and small doses of penicillin.

TABLE 2.—*Data Comparing the Incidence of Complications for Patients Under 7 Months with Patients Over 7 Months.*

AGE	NUMBER OE CASES	DEATH (%)	RESIDUAL BRAIN DAMAGE (%)	SUBDURAL EFFUSION (%)
Under 7 months	22	14	18	27
Over 7 months	38	11	13	5

The two cases of Salmonella meningitis were both found sensitive to chloramphenicol and were treated with adequate amounts of this drug (70-300 mg/kg/day).

The one case of staphylococcal meningitis was treated for one week with small doses of penicillin, 120 mg/kg/day of sulfadiazine and 60 mg/kg/day of streptomycin. At the end of one week, the treatment was switched to oxytetracycline (100 mg/kg/day) when sensitivity tests showed good inhibition with this drug.

All but three of the 22 cases in which an organism was not identified were treated with small doses of penicillin in combination with adequate doses of a sulfonamide and streptomycin. In addition, 14 received one of the broad spectrum drugs in adequate dosage.

Mortality and Complications.—For the entire series of 60 cases there were seven deaths, seven survivors with severe residual brain damage, two survivors with minor residual brain damage and eight cases of subdural effusion. Five of the deaths were due to influenzal meningitis and two to pneumococcal. Their ages were 3, 5, 5, 15, 21, 24, and 24 months, and they expired five hours, eight hours, sixteen hours, twenty hours, three days, eleven days and five and one-half months, respectively, after admission to the hospital.

Three of the cases of severe brain damage were due to influenzal meningitis and one to pneumococcal; three were in the group in which the causative organism was not identified. The ages of these cases were 2, 4, 4, 11, 12, 14, and 15 months.

Subdural aspirations were attempted in 12 cases because of persistent fever, vomiting and bulging fontanel. Effusions were found in eight. All except two were less than seven months of age. Three were due to the influenzal type and one to pneumococcal, and four were in the undetermined group. Exploratory craniotomy with removal of a membrane was done in three. One of the patients with an effusion expired. Four were associated with severe residual brain damage. Four were bilateral.

"Early Treatment" versus "Late Treatment."—Thirty-four (57 per cent) of the cases were treated for meningitis before the patients were critically ill and these are included in the "early treatment" group. Eleven were cases of influenzal meningitis, one pneumococcal, four meningococcal, one Salmonella, one staphylococcal, and 16 of undetermined cause. The "late treatment" group consisted of 26 cases of which 12 were due to the influenzal bacillus, five pneumococcal, two meningococcal, one Salmonella and six of undetermined cause.

The mean age of the "early treatment" group was 16 months with 32 per cent being under seven months. The mean age of the "late treatment" group was 11 months with 42 per cent being less than seven months. Sixty-eight per cent of the "early treatment" group and 50 per cent of the "late" received optimal antimicrobial therapy as defined above.

The average duration of fever after the onset of therapy was six days for the "early" group and eight days for the "late." The average duration of hospitalization was nineteen days for the "early" group and thirty-five days for the "late."

There were no deaths in the "early" group; all seven deaths occurred in the "late" group.

One of the "early" group had residual spasticity. Six of the "late" group survived with severe residual brain damage. The residua consisted of hydrocephalus, mental retardation, hemiparesis, and spasticity. One from each group had minor residual neurological abnormalities: transient strabismus and transient diabetes insipidus. Two from the "early" group developed subdural effusions. Both subsided with conservative treatment. Six from the "late" group developed effusions and three of these required surgical treatment.

Table 3 is a comparison of the mortality and morbidity for the "early" and "late" groups. Chart 1 illustrates in diagrammatic fashion the prognosis for meningitis suggested by this study.

"Optimal Therapy" versus "Non-Optimal Therapy."—Of the 36 patients receiving optimal therapy for the type of meningeal infection pre-

TABLE 3.—*A Comparison of "Early Treatment" Cases with "Late Treatment" Cases.*

	NUMBER	NUMBER UNDER 7 MOS.	MEAN AGE (MOS.)	DURATION SYMPTOMS (DAYS)	DEATH	SEVERE RESIDUA	MINOR RESIDUA	SUBDURAL EFFUSION
I. "Early Treatment"								
A. "Optimal therapy"	23*	8	15	2	0	0	1 (4%)	2 (9%)
B. "Non-optimal therapy"	11†	3	16	2	0	1 (9%)	0	0
C. Total (A and B)	34	11	16	2	0	1 (3%)	1 (3%)	2 (6%)
II. "Late Treatment"								
A. "Optimal therapy"	13‡	6	8	2½	2 (15%)	2 (15%)	0	4 (31%)
B. "Non-optimal therapy"	13¶	5	14	3½	5 (38%)	4 (31%)	1 (8%)	2 (15%)
C. Total (A and B)	26	11	11	3	7 (27%)	6 (23%)	1 (4%)	6 (23%)

* 8 H. Inf., 0 D. Pneu., 4 N. Men., 10 Unident., 1 Salm.
† 3 H. Inf., 1 D. Pneu., 0 N. Men., 6 Unident., 0 Salm., 1 Staph.
‡ 6 H. Inf., 0 D. Pneu., 2 N. Men., 4 Unident., 1 Salm.
¶ 6 H. Inf., 5 D. Pneu., 0 N. Men., 2 Unident.

sent, 23 were in the early therapy group (twenty-four to forty-eight hours) and of these, there were no deaths, no residua, and two effusions and one transient strabismus. In the other 13 cases considered "optimal" but "late" treatment, two died, two had severe residual damage, one had minor residual brain damage, and four developed effusions.

In the group considered not to have received optimal therapy, 13 cases got early treatment but still two died, two had severe damage, and four had effusions, and of 13 receiving "late" treatment in this group, five died, four had severe residua, one minor residua, and two had effusions.

A Plan for Optimal Therapy

The treatment of meningitis while waiting twelve to forty-eight hours for culture identification, and the treatment of the cases of unknown etiology, has been a relatively neglected subject in the medical literature. Etteldorf[5] and Smith and Herring[6] have both presented plans of therapy which include the use of penicillin, a sulfonamide and chloramphenicol for these occasions.

Since any delay in initiating optimal therapy in bacterial meningitis increases the chances of death or permanent brain damage, we believe that the early treatment of all cases should "cover the field in an optimal fashion," e.g., be optimal for the meningococcus, the pneumococcus and the influenza bacillus. At the present time this means giving sulfonamides, massive doses of penicillin and a broad spectrum drug. If and when definite identification, either by quellung or culture techniques, is made, the regimen can be altered appropriately. If no organism is ever identified, all three drugs should be continued for the entire course of therapy.

We suggest using the following plan:

1. **For the first twelve to twenty-four hours, or until the patient is no longer acutely ill.**
 - Aqueous crystalline penicillin—IM or IV—1 million units each 2 hrs.
 - Sulfadiazine or Gantrisin—SC, IM or IV—75 mg/kg each 6 hrs.
 - Chloramphenicol—IV—15 mg/kg stat and each 6 hrs.
 or IM—100 mg/kg stat and each 12 hrs.
2. **After the first twelve to twenty-four hours, or when the patient is no longer acutely ill.**
 - Aqueous crystalline penicillin—IM—50,000-100,000 units/kg each 6 hrs.
 - Sulfadiazine, Gantrisin or triple sulfa—PO—50-75 mg/kg each 6 hrs. (not to exceed 6 grams in 24 hrs.)
 - Chloramphenicol crystalline—PO—20 mg/kg each 6 hrs. (not to exceed 3 grams in 24 hrs.)
3. **After the causative organism is identified (by culture or by quellung reaction).**
 - For H. influenzae: Continue the sulfonamide and chloramphenicol.
 - For D. pneumoniae (or Str. pyogenes): Continue the penicillin and sulfonamide.
 - For N. meningitidis: Continue the sulfonamide.
 - For M. pyogenes: Continue all three drugs and make changes in accordance with the clinical response and the sensitivity tests.
 - For other Gram-negative rods: Continue the chloramphenicol and sulfonamide and make changes in accordance with the clinical response, sensitivity tests, and the available data on the drug of choice for the specific organism identified.

The dose of sulfonamide should be adjusted in order to keep the serum level between 10 and 15 mg per cent. It is advisable to administer sodium lactate parenterally or sodium bicarbonate orally while using sulfa drugs. If the palmitate form of chloramphenicol is used orally instead of the crystalline, the dosage should be increased to 50 mg/kg each six hours. Tetracycline may be substituted for chloramphenicol if desired in a dosage of 50-100 mg/kg/day.

The duration of therapy depends upon the clinical course, the abatement of fever and the spinal fluid findings. A good general rule is to continue treatment for ten to fourteen days or until the patient has been afebrile for five days.

If fever persists longer than five to seven days, a complication such as a subdural effusion may have occurred and subdural aspiration should be done if the coronal suture is open. Often the persistent fever is associated with a bulging fontanel, vomiting, poor appetite, poor weight gain, irritability and localized or generalized neurological signs. There is now fairly general agreement that exploratory craniotomy should be done if the effusion does not "dry up" after ten to twenty daily aspirations.[7] If it is not possible to do subdural aspirations through the coronal suture, an exploratory craniotomy should be considered after two to four weeks if clinical evidence indicates an encapsulated subdural effusion, e.g., persistent fever, vomiting, irritability and localized or generalized neurological findings.

It is not our purpose to imply that the plan presented above is the only method which can be used for the successful treatment of meningitis. There are numerous remedies and variations in methods. We do believe that this plan provides optimal antimicrobial treatment and will give good results.

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[6] Smith, M. H. D., and Herring, G. W.: The Treatment of Acute Bacterial Meningitis in Infants and Children, Postgrad. Med. 14:540 (Dec.) 1953.

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Discussion

Early diagnosis of meningitis in small infants is not easy. Often there are no signs of meningeal irritation and the diagnosis is made by a "hunch" spinal puncture on a baby with an unexplained fever.[8] Often the infants who are the most desperately ill are the ones who lack meningeal signs.[9] Certainly it is wise to do a spinal puncture on any infant who has an unexplained febrile convulsion. The administration of antimicrobials for unexplained fevers is often condemned because of the associated dangers of "masking" a serious infection.[10]

At the present time, the mortality rate for meningococcal meningitis treated with one of the sulfa drugs is five per cent; for influenzal meningitis treated with one of the broad spectrum drugs five to ten per cent; and for pneumococcal meningitis treated with massive doses of penicillin and sulfa drugs 10 to 20 per cent.[11] Accumulating evidence suggests that equally good results may be obtained by use of one of the broad spectrum drugs as a single agent.[12] Until more evidence is available, however, it is not deemed wise to limit treatment to such an extent.

Intrathecal medication and rabbit antiserum have been abandoned in almost all instances because of the dangers and the lack of evidence that they offer any advantages.[13] Hoyne[14] advocates limiting the use of the spinal puncture to diagnostic purposes only.

Whether to use chloramphenicol or one of the tetracycline drugs, in the treatment of meningitis due to H. influenzae or an unidentified organism, is a controversial subject. Although it cannot be said with finality that chloramphenicol causes blood dyscrasias, the burden of evidence indicates that it may be at least partially responsible for the development of aplastic anemia in certain rare sensitive individuals.[15] To our knowledge its use has never been associated with any hematological disturbance in the treatment of meningitis with the doses recommended here. Chloramphenicol is favored over the tetracyclines because of its better gastrointestinal absorption and tolerance, its higher spinal fluid levels, and its greater effectiveness against the influenza bacillus and certain other of the Gram-negative rods.[16] The tetracyclines are usually adequate substitutes for chloramphenicol and have been shown to give good clinical results in spite of low spinal fluid levels.[17] Hoyne[18] has stressed on many occasions the importance of treating the patient and not the spinal fluid.

The recommendation of the use of combinations of antimicrobials raises the question of possible interference of one drug with another. Several reports of interference observed in the experimental laboratory have appeared.[19] Thus far, the only clinical evidence to support these laboratory findings has been the report of Lepper and Dowling.[20] In the treatment of a comparable series of cases of pneumococcal meningitis, they reported a mortality rate of 30 per cent following the use of massive doses of penicillin alone and 80 per cent with a combination of massive doses of penicillin with chlortetracycline. Austrian[21] is adamantly opposed to the use of any of the bacteriostatic agents combined with penicillin for the treatment of pneumococcal meningitis. He states that penicillin is most effective upon dividing bacteria; therefore, its action is nullified if bacterial growth is arrested by bacteriostatic drugs. Warning and Smith's work[22] indicates that this may not always be true. They showed a marked reduction in the mortality from pneumococcal meningitis by the use of a combination of penicillin and sulfa instead of

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[c] Ross.[8]

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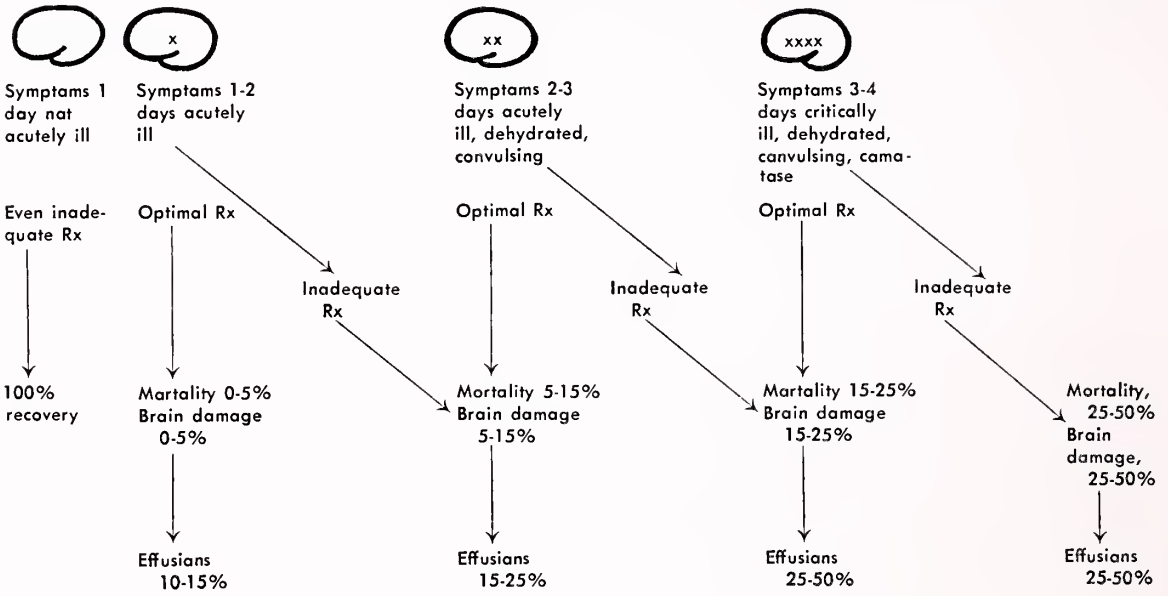
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CHART 1.—*Diagrammatic Prognosis Chart (a Generalization Suggested by this Study).*

(The number of x's represents the amount of brain damage present prior to the onset of treatment.)



penicillin alone. There have been many other clinical reports that failed to show any antagonism between the broad spectrum antibiotics and penicillin.[23] On some occasions the use of combinations of antimicrobials has been shown to be of importance in the prevention or delay of the emergence of resistant strains.[24]

The formation of subdural effusions during the course of a bacterial infection of the meninges is apparently a part of the recovery process. Before the advent of effective therapeutic agents for the treatment of meningitis, these collections were not seen clinically or at the autopsy table.[25] Smith *et al*[26] in 1951 reported subdural effusions in 50 per cent of a group of cases of bacterial meningitis. In that series, all the patients with open fontanels had diagnostic aspirations of the subdural space. Ingraham and Matson[27] reported a series of 50 cases of post-meningitic subdural effusions. Fifty per cent of the cases were associated with influenzal meningitis, 20 per cent with pneumococcal and 15 per cent with meningococcal. Alexander[28] does not believe that subdural effusions are necessarily associated with cerebral damage either at the time of the acute infection or during convalescence. She states that the incidence of brain damage following recovery from bacterial meningitis is closely related to the extent of cerebral cell damage which is present at the time treatment is started. She also believes that the recovery rate for meningitis should approach 100 per cent when the treatment is started early in the course of the disease. This last supposition is well borne out by the results of this present study.

Summary

A review of 60 consecutive cases of non-tuberculous bacterial meningitis treated at the Kauikeolani Children's Hospital from 1950 to 1955 is presented. The mortality rate was 12 per cent, with a 12 per cent incidence of severe residual brain damage and a 14 per cent incidence of subdural effusions in the cases that recovered. There was no severe residual brain damage and no deaths in the cases receiving early optimal treatment, in contrast to a mortality rate of 38 per cent and a 31 per cent incidence of severe residual brain damage in those patients receiving late, non-optimal treatment. A plan for optimal therapy of bacterial meningitis is presented, and a review of the medical literature on the diagnosis, treatment and complications of meningitis.

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MYOCARDIAL INFARCTIONS AT THE QUEEN'S HOSPITAL

January 1, 1950 to January 1, 1955

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Of 433 cases of myocardial infarction treated at The Queen's Hospital in a five-year period, 131 (30%) died. The mortality was 44% in those who did not receive anticoagulants and only 15% in those who did.

OCCLUSIONS of the coronary arteries may be caused by many types of lesions, of which arteriosclerosis is by far the commonest. Wartman,[1] in a series of cases, showed that coronary thrombosis is usually associated with arteriosclerosis. It was present in 93 per cent of coronary obstructions studied.



DR. GOTSHALK

In 1949 Gotshalk and Bell[2] reviewed the incidence of myocardial infarction treated at The Queen's Hospital from January 1, 1943, to January 1, 1948, many of these due to thrombotic arteriosclerotic occlusion. In the Territory of Hawaii from 1950 to 1954, there were 1,285 deaths due to myocardial disease with involvement of the coronary arteries. Because of this high incidence, I thought that it might be wise to review the occurrence of this disease at The Queen's Hospital during this same period, as a basis for comparison with the previous study.

Material Used and Selection of Cases

The clinical data were selected from The Queen's Hospital records between January 1, 1950, and January 1, 1955. During this period there were 68,551 patients discharged from the hospital, of whom 28,368 were males and 40,551 were females. During this same period, 1,696 deaths occurred.

Of the 68,551 patients discharged there were 433 cases of myocardial infarction, 346 males and 87 females. Among the males there were 107 deaths, and in the female group there were 39, a total of 146.

All of the cases selected had clinical and electrocardiographic evidence of myocardial infarction. In the series of 146 deaths, there were 99 autopsies, an autopsy rate of approximately 68 per cent.

In the present study I was interested in: (1) the age incidence of both male and female patients; (2) the race and nationalities affected; (3) associated degenerative diseases; and (4) the effect of anticoagulant therapy on the mortality rate.

Age and Sex Incidence

In the male series the youngest was 29 years and the oldest 103 years. The peak incidence was reached between the ages of 55 and 60. In females the youngest was 40 years, and there was a gradual rise up to 80 years.

The series follows the pattern shown by Peel[3] for 865 cases.

TABLE 1.—*Board of Health and Hospital Statistics by Age and Race.*

RACE OR NATIONALITY	POPULATION	NUMBER OF DEATHS MYOCARDIAL INFARCTION 1950-54	QUEEN'S HOSPITAL SERIES	
			Cases 1950-54	*Deaths* 1950-54
Hawaiian	10,000	109	13	6
Part-Hawaiian	86,000	105	23	11
Puerto Rican	9,000	25	14	6
Caucasian	101,000	457	294	97
Chinese	33,000	122	33	13
Japanese	188,000	350	34	9
Korean	7,000	30	4	1
Filipino	62,000	103	17	3
All Others	4,000	4	1	0
TOTAL	500,000	1,285	433	146

Race and Nationality

The territorial population is made up of many

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racial groups, which makes this type of analysis especially interesting.

In Table 1 there is, in the second column, a statistical analysis of the territorial population by racial origin. In the third column is the incidence of myocardial infarction according to the Territorial Board of Health Statistics. From these figures it is evident that the Hawaiian, Puerto Rican, and Caucasian have the highest incidence of myocardial infarction. However, from these figures alone no conclusions can be drawn, since the age spreads of the various groups must be considered. The high incidence of myocardial infarction among the Hawaiians is interesting. Many of this racial group are overweight and eat a diet rich in carbohydrates and fats.

Degenerative Diseases Associated with Myocardial Infarction

Since myocardial infarction is a result of arteriosclerosis, generally considered a degenerative condition, it is interesting to see what other similar degenerations were associated with the cardiac condition.

In this series there were 193 cases of hypertensive cardiovascular disease associated with myocardial infarction, resulting in 77 deaths. In 47 cases auricular fibrillation and congestive heart failure were present. In 41 cases diabetes mellitus was present. The remainder of degenerative diseases represent a cross-section generally seen in older age groups.

Anticoagulants

In this series of 433 cases, 156 received anticoagulant therapy. The drugs chosen were heparin or dicumarol, or both. None of the newer drugs of the coumarin series were used.

Heparin was usually used at the onset of an infarction, until the ideal dicumarol effect was obtained, and then it was discontinued. The purpose of heparin was to prolong the clotting time from 14 to 20 minutes, which was a range considered satisfactory to prevent intravascular clotting.

Dicumarol effect was determined by the Quick[4] one-stage method in which the prothrombin determination was made by adding thromboplastin reagent and calcium chloride to oxalated plasma. The time for clot formation was determined.

The prothrombin concentration was then determined, using the familiar hyperbolic dilution curve on which a prothrombin time of one-half longer than that of normal controls corresponded to a content of approximately 30 per cent, while a value of about twice that of the normal controls corresponded to a diminution to about 10 per cent. Thromboplastin reagent was selected so that the control times were about 18 seconds. The usual therapeutic range aspired to was between 10 and 30 per cent. It usually took two to three days to obtain this effect.

In this series of 433 cases, 277 were treated only with bed rest, oxygen, and other symptomatic therapy. In this group there were 122 deaths (44%).

In the 156 cases treated by anticoagulants, oxygen, bed rest, and other symptomatic treatment, there were 24 deaths (15%). In 68 cases of this 156, an effective therapeutic range of treatment was maintained for three to four weeks, and in this group, there were nine deaths.

It is impossible to draw conclusions from such a small series of cases, but it appears that patients who received adequate anticoagulant therapy did better as a group.

Discussion

The cause of coronary sclerosis, which is the most common contributing factor to myocardial infarction, has not definitely been established. Winternitz,[5] in a splendid monograph, outlined some of the present day concepts of coronary sclerosis. Katz[6] believes that hormones and diet play an important role in atherogenesis. In addition Kapp[7] has postulated trauma due to nonpenetrating chest injuries, and unusual physical stress, as factors in the production of thrombosis in a sclerotic vessel or perhaps independently.

There is considerable basic research to be done before this many-faceted problem can be solved.

Summary and Conclusion

A statistical study of heart disease due to myocardial infarction in the largest private general hospital in the Territory of Hawaii is reported. There seem to be indications that properly controlled and administrated anticoagulant therapy may produce better results than treatment without these drugs.

Acknowledgment

I am indebted to Dr. Harold Civin for his help and cooperation.

[4] Quick, A. T., Stanley, B. M., and Bancroft, F. W.: A Study of the Coagulation Defect in Hemophilia and Jaundice, Am. J. Med. Sci. 190:501 (Oct.) 1935.

[5] Winternitz, M. C.: Views as to Causes of Coronary Sclerosis, in Blood, Heart and Circulation, Washington, D. C., The Science Press, 1940, p. 114.

[6] Katz, L. M.: The Role of Diet and Hormones in the Prevention of Myocardial Infarction, Ann. Int. Med. 43:930 (Nov.) 1955.

[7] Kapp, L. A.: Trauma in Relation to Coronary Thrombosis: A Clinical Study of 42 cases of Coronary Thrombosis Following Trauma or Unusual Effort, Ann. Int. Med. 40:327 (Feb.) 1954.

OPERATION BREAKDOWN

A Fantasy of a Mental Hospital as an Island

HARRY A. WILMER, CMDR., MC, USNR, Oakland, Calif.

An amusing and instructive allegorical look at the human race as it functions in a Naval psychiatric hospital.

THE PURPOSE of this communication is to describe an archipelago of islands surrounded by a coral reef, which is possessed by a powerful nation; and to offer a glimpse into the influence of this environment upon the inhabitants. These people come from an order of men on the mainland who are segregated from the general population and who own allegiance to the Great Chief. The islanders are of two classes: those who administer the archipelago, and those who are sent there for readjustment because they have failed to adapt themselves to the particular order of which they are members.



DR. WILMER

The Great Chief and each chief of lesser rank in the mainland hierarchy are thought to care for all their men alike; this is a necessary illusion. When a man, having been accepted into the order, displays bizarre or peculiar behavior calling unfavorable attention to himself, he is immediately sent to the outpost, where emissaries from the archipelago are available to decide whether or not he should be sent on at once to the archipelago. Sometimes the individual is sent by people who fear his strange behavior might be contagious; they see in it things they fear within themselves, hence they rush him to the emissaries. There are also men sent to the emissaries because of inability to work, think, talk or feel—disorders in the range of phenomena thought of by some as "sickness."

The frame of existence on the archipelago is known as Operation Breakdown. Operation Breakdown becomes for the island administrators Mission Reassembly; this indeed is the working goal throughout the island group—to return men to the social order from which they came and to return them as functioning individuals. The transient population of the islands remains only for intervals of weeks or months.

It should be emphasized that the stability of the archipelago's social orders does not rest with the people who occupy it, but rather with the stability of the larger order to which all these men belong and to which most pay homage and loyalty. No man is granted a home of his own. Existence is communal and somewhat primitive, but with immediate access to modern conveniences. The food is of the most desirable sort and the most modern dietary program is followed. Since none of the islands can sustain itself alone, food is brought to each daily. Within the memory of man, there has been no time of famine. Many races of people are represented among the islanders, since they come from many races belonging to the mainland order. I myself belong to this order of men and was sent to one of these islands to function as its chief. During a year's sojourn, it has been possible to make certain anthropologic and histographic observations.

The Islands

Eight islands comprise the archipelago within the surrounding coral reef. Curiously, they have no names but are arbitrarily designated by number. Each varies in size and character and each is peopled by a distinctive group. The largest island is known colloquially as Big Island, officially as No. 56. It has the greatest wealth and richest natural resources, and is thought by many to be the most attractive of all, having more shade by virtue of forestation, and no great open windswept plains. In the lagoon entrance lies an islet known as No. 55; it stands in such relationship to the navigable channel that it is necessary to pass over the islet before proceeding to any of the adjacent islands. In the mornings, considerable fog overhangs this atoll, so that it becomes isolated to an appreciable extent from its neighbors, and clouds lower constantly over the hills. Because of the prevalent fog, various legends and myths have crept into the folklore of the archipelago as to the customs and practices on Island 55. It has also been in the vortex of quite heavy storms, most of them sweeping down from Island 54 immediately to the north of it.

The opinions contained herein are those of the author and are not to be construed as official or reflecting the views of the Navy Department or the Naval Service at large.

This next one, No. 54, is the most unusual of the chain in that it is almost entirely volcanic; frequently subterranean rumblings are heard and puffings of smoke, gaseous matter and eruption of cinders are seen in the mountains at its western limit. The possibility of volcanic eruption has tended to threaten Island 55 on a number of occasions, but for the most part the volcanos have only made noise and cast up cinders, temporarily blinding the people visiting it. No. 55 has weathered a number of typhoons within the memory of recent inhabitants. On its eastern border is a sheltered and attractive valley, hidden from view by surrounding mountains. Indeed it is the only valley in the whole archipelago.

Island 53, small and verdant, lies next. It is covered by vegetation of quite a prolific and variable sort, and while it produces no crops or products of permanent value to sustain the residents, its beauty has always been admired and occasionally praised in their poetry and chants.

Just beyond No. 53 is Island 52—barren, cold and bleak, ringed by crags and with rugged coastal terrain. It is the most undesirable and foreboding of all, with hulks of wrecked ships scattered about its edges, craft destroyed in the treacherous tide-rips among the rocks far out beyond its approaches.

A considerable distance to the northeast is Double Island 51: rugged and large, composed of sloping tree-clustered hills, it has a great open plain at both its northern and southern ends. Two more Double Islands, 49 and 47, nestle close to each other, separated only by a narrow strait; this passageway is no obstacle to ready access between the islands. No. 49 is flat, with an even, sandy coastline, while Island 47 is very large, has outer shoals and a coastline of high rocky cliffs and bluffs. Frequent storms visit it, and passage to and from it is exceedingly difficult. No. 47 is considered less desirable, but this has more to do with the nature of its particular tribe of inhabitants than with its physical aspect, although it is formidable and unattractive. The residents are sometimes said to be wild men and the chiefs known as head-shrinkers. This is totally untrue.

Behavior and Assignment of Residents to Islands

The population varies considerably in behavior from island to island. Each island basically is a tribe unto itself; all inhabitants are warriors, and all tribes pay allegiance to the same great war chief and have been known to unite against common enemies. On No. 56, the residents live in separate, private quarters and enjoy greater freedom, having come from a higher mainland stratum. Indeed they are all people who were chiefs in their own right before being sent to the archipelago. For this reason, they now occupy the most desirable location. The behavior on No. 55 varies the most, since all newcomers to the archipelago passing through the inlet and coral reef must go through the shoals of No. 55, and most of them stay in the small dwellings around its edge for at least a week or ten days before being sent to tribes or social units on other islands.

The immediate adjustment to a new social order is most striking here. At this very point the problem of acculturation has its inception. Here each individual is observed and interviewed, and participates in rituals led by the chief. No individuals are sent to the volcanic island to the north, and none to the garden island still farther beyond; rarely is one sent to the barren island unless he has previously been in such difficulty as to warrant his temporary exile as a form of punishment. The chief of Island 55 decides, therefore, whether to send a newcomer to rugged Double Island 51, to flat and barren Double Island 49 or to rugged, stormy Double Island 47. The decision is usually made on the basis of behavior and comformity. Those who need the security of No. 47's rugged coastline (so they may not fall into the sea nor wander offshore into deep water) are sent there. Those able to move about, act responsibly and with sufficient self-control and conformity to accepted patterns and values are sent to No. 49 or No. 51. The newcomers show varying degrees of acceptance of their being ordered to the archipelago. Some are bitter, some grateful, some indifferent.

Following the few months' stay, the residents must leave the archipelago in one of three ways; the choice rests with three chiefs who confer together and decide: (1) as a temporary inhabitant on a small "reassignment" island beyond the coral reef, while waiting final return to the mainland order from whence he came; (2) direct return to the mainland but no longer as part of the Order, sometimes being financially rewarded because of the difficulty which led to his temporary island sojourn (this strange reward value system having a profound influence upon the islanders); (3) an individual may be sent to a still more distant archipelago for prolonged residence.

Tribal Hierarchy: Chiefs

These eight islands and other neighboring archipelagos beyond the reef are all under the jurisdiction of a High Chief residing on another island belonging to the powerful government presided over by the Great Chief. The High Chief is in constant communication by the most modern means with the Great Chief on the mainland.

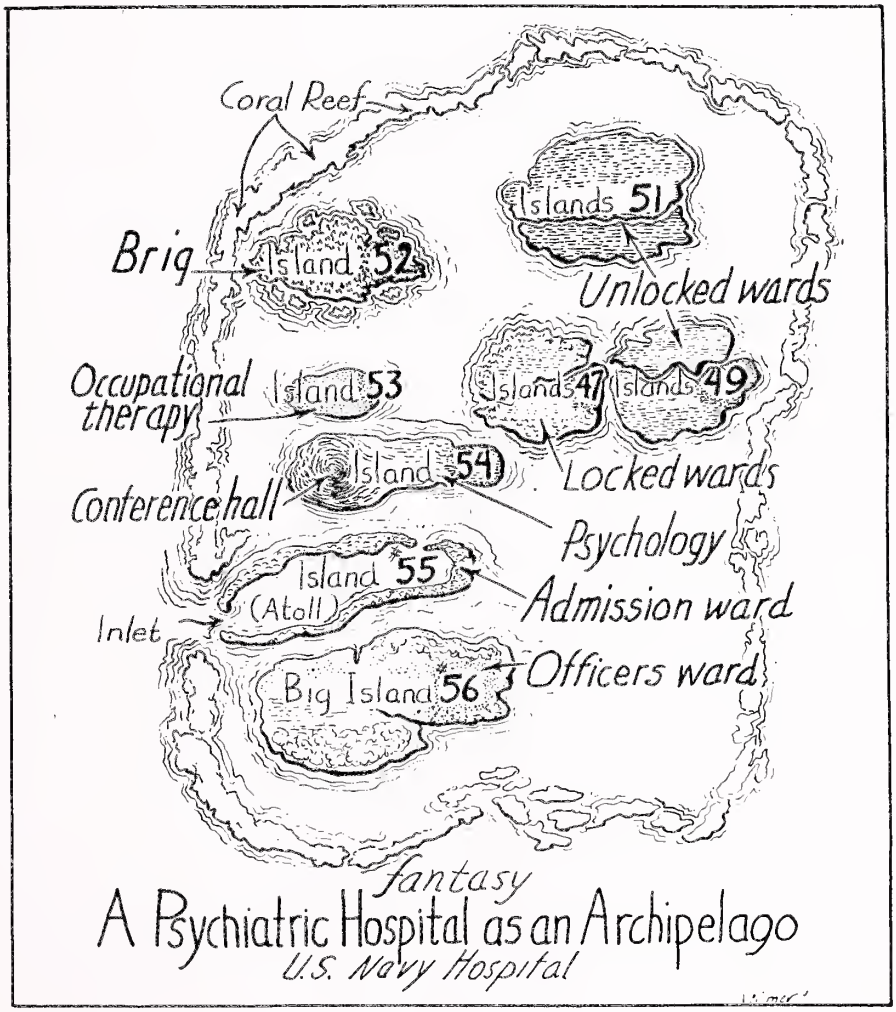
Each island is ruled by a chief. In my archipelago, the chief of Big Island 56 is the most powerful, though less so than the High Chief on the distant island or the Great Chief in the homeland. In the island cluster, the power of Big Island Chief is almost total, all other chiefs being subordinate to him. Each chief has as helpers a number of younger men of secondary chieftain status, and several pleasant, courteous women who are interested in the welfare of the islanders but are strictly taboo as sexual objects, remaining a vague sort of mother or goddess figure to them. They wear insignia to indicate their status, the women being of a higher order of power than the young male subchiefs. The only visible distinction between many of the common populace and the subchiefs is that of costume.

Big Island Chief is the only one to occupy the same spot year after year. The social structure and custom of this peculiar society require that the other chiefs interchange from island to island, governing now one and then another, remaining on one for months or as long as a year, but rarely longer. There is a rumor within present memory that one chief did remain for three years on an island, but this has not been verified. The chiefs

Figure 1 is a diagram in fantasy describing the mental hospital wards of the psychiatric service at a naval hospital. The islands are wards: No. 56 is Officers and Females; No. 55, Admission; No. 54, Psychology and also staff conference rooms; No. 53 is Occupational Therapy and Gymnasium; No. 52, the Brig; No. 51 (A and B sides), unlocked wards; No. 47A and B, locked secure wards; No. 49A and B, unlocked wards. These buildings are scattered about terrain which was once a golf course, and nearby are the other wards of the hospital: medical, surgical and the other specialties. The compound is surrounded by a high wire fence and the yards of the locked wards are similarly enclosed. The ward buildings are all separate temporary wooden structures and, with the exception of No. 56, are large open wards with 34 to 40 beds lined up, half on each side. There are seclusion rooms on the locked wards.

The volcanic eruptions refer to the staff meetings, and the general cultural milieu is of a military hospital section staffed by reserve drafted doctors and regular Navy doctors, all of them psychiatrists but with varying training and experience.

It is clear to the author that much of the criticism leveled at this particular social unit is a reflection not so much upon the military hospital society as upon the failure of adaptation by the criticizers; this is a far more subtle reality and is not so ready a target as the big impersonal organization known, interestingly enough, as a military "outfit." Too much outfit and not enough infit. But for the most part, it is impressive how smoothly and efficiently it operates despite the obstacles inherent in human limitations.



are chosen to guide the tribal societies in this archipelago for a period of two years and are then sent elsewhere. Their function is described in the prevailing tongue as YRTAIHCYSP, pronounced yurt-ay-sisp.

All of the chiefs belong not only to the social order which administers these islands but also to a sub-order devoted to caring for people, which may, at times, be the highest expression of human devotion but which sometimes assumes the nature of a cult, with a degree of confusion secondary only to that among the tribesmen. All too often the great oaths and ideals of the sub-order are forgotten, and the consequences blamed on the society rather than on personal negligence of the chiefs who break faith with the oaths and ideals.

Attitudes of Chiefs

The archipelagic hierarchy is of such rigidity that it often matters little which chief is on which island, and indeed, which inhabitants are on which island, for the social order of things seems to continue, in any case, with remarkably little variation. There is, however, considerable difference in the chiefs, both as to their interest in their tribal charges and their interest in the Order to which they belong. Unquestionably, devotion to the Order facilitates good functioning in the chiefs. There are two orders of belonging among them: one for life, or at least the whole of their working life, and the other for periods of a few years. Those who belong for life are not necessarily better chiefs, but in general are more devoted to the Order. Unfortunately, suspicion and distrust sometimes occur between these two elements, some of which, regrettably, is well founded.

Insignia, Garb and Rituals

The chiefs wear insignia showing which are more powerful by virtue of seniority. The tribe members seem to pay great attention to this relative power, and the lesser chiefs frequently envy their superiors. Each chief, however, being the sole authority on his own island, frequently rallies his tribe about him in certain ritualistic proceedings and incantations held at regular daily intervals, or less often, developing almost a spirit of cult. These tribal meetings serve the purpose of carrying out the mission of the operation. The group tension on each island is occasionally quite high and may reflect anxiety in the chief, so that harmonious existence between the various tribes —the ingroups and the outgroups—is precarious, but nonetheless does exist.

The ritualistic observation of conformity in garb is rigid and inflexible. The tribesmen all wear unattractive garments, usually in varying shades of blue, with buttons or tie-strings: simply pants and a short jacket and frequently little else. On some of the islands with easier approach, they wear more formal dress of dark blue or white, embellished by insignia previously worn on the mainland or on the ships plying between mainland and outpost.

Powers and Dangers

So complete is the authority of each island chief, if he wishes to exercise it, that his tribe would live in terror. It is beyond the scope of this communication to discuss the various uses of power, but the source of greatest anxiety in the chiefs is the fear that something will happen to their charges and that they, the chiefs, will be held accountable. One of their darkest fears is that a tribesman will destroy himself by suicide. If this transpires, the chief, by custom, will be held strictly accountable unless it can be shown that he has not failed in his responsibility. This custom is altogether unrealistic in that it presupposes that security and safekeeping are absolutes, which they are not; also, it presupposes that such security measures are *always* in order if in any doubt, which leads to their abuse; their value for the tribe is by no means certain, and in most cases they are useless and detrimental and would never be used except for their magical power of "keeping covered." Moreover, the penalties under the custom make chiefs behave in strange ways toward each other, wishing to take no personal responsibility for any mishap—which is understandable if not commendable.

As an outgrowth of this somewhat irrational attitude, and to protect the chief (and less often, the tribe members), a series of small cells for solitary confinement can be found on a number of the islands, for the incarceration of individuals. These are used either as punishment (though this is rarely admitted) or to protect the individual from his destructive impulses. Tribal behavior has on some occasions reached the point of disorder and riot, but swift accessibility of security and police forces in neighboring archipelagos has reduced these violent interludes to short duration.

Communication between the islands, while mechanically perfect, is frequently functionally imperfect. There are chiefs who rarely talk to other chiefs; there are chiefs who dislike other chiefs, who are jealous of their colleagues and harbor all the human characteristics of distrust, anxiety and fear that make communication so difficult. There are, however, *official channels of communication* relative to tribal conduct which are fulfilled, usually with dispatch and exactitude. These necessary *official* communications are indeed essential to op-

eration of the archipelago, but sometimes cause irrational resentment.

Inter-island communications and messages from island headquarters to the mainland are largely in code language which is often unintelligible to the uninitiated. The reason for an individual's presence on an island is often designated merely by four numbers. Where he will go is commonly denoted by a combination of numbers, and certain parts of the mainland are similarly specified. There is a compulsion for numbers, order and code communication that has been known to drive some people to this particular archipelago, but for others it has been a source of stability and adjustment.

Labors, Rewards and Punishments

Within the encircling coral reef, certain inhabitants are accorded the privilege of going from island to island as they choose, during waking hours. There are relatively few demands upon their time, as little work is demanded of them, other than the cleanliness and orderliness of their islands. They neither reap the harvest nor prepare their food. They do not manufacture for sale. The only things expected of them are conformity, obedience, good behavior and social adaptation. In return for these—or even without them—they receive money regularly in the form of wages for services they are unable to render. Some of the tribesmen, however, are actually incapacitated for work. On the mainland, a highly organized system of rewards by means of presentation of trinkets of metal fastened to multicolored bits of ribbon is practiced. The design of the trinket denotes its relative worth, and the color of ribbon is different for each. They are greatly esteemed by the islanders, but it is strictly taboo to wear these decorations unless one has actually been awarded them, as is the case for all insignia.

Disapproved behavior, usually bringing punishment, includes drinking, desertion, sleeping at undesignated hours, uncleanliness, or disregard for the customs cherished by the larger Order. Any tribesman who wanders beyond the coral reef is subject to severe punishment unless he possesses a sign given him by his chief. Instances of sabotage of an island or of the Order, by both the tribal members and the chiefs, are known to exist. There has been no serious example of this within recent years, but numerous minor examples occur frequently. Punishment usually comprises restriction to an island or banishment to Island 52. Other punishments are consistent with concepts of mainland justice such as fines, imprisonment or hard labor. Such punishment is kept at a minimum because of the nature of Mission Reassembly.

Attitudes Beyond the Coral Reef

Unfortunately there exists, as a subtle form of punishment within the large Order, a stigmatization of men returning from this archipelago, so that many who might ordinarily return and once again function well become non-conforming and non-believing or suffer from varying degrees of sickness and must return to the archipelago—all this because, having once been there, they are erroneously thought of as being different or strange. This is probably because the Order on the mainland cannot easily tolerate differences, lack of conformity and behavior which they in themselves have struggled to master, with varying success. By stigmatizing the returning men, they deny in themselves what they really fear, thereby causing more casualties. There is an element of quarantine-like isolation about the archipelago that pleases most of the people outside it and frightens many of the ones sent there.

Summary

I have described a series of islands in an archipelago, on one of which I have been chief for approximately one year. It has been enjoyable and profitable. It has given me an opportunity to study human nature and the social conformity and nonconformity of people under a highly controlled, artificial situation of groups forced to live in close proximity for short periods of time.

It has provided an opportunity to learn about problems of communication and obstacles to communication; about the erroneous concept of protection and ways of repressing and controlling violence.

It has given me an opportunity to be a father as well as a chief to the men on my atoll, and in return for this, to gain their respect and the respect of the subchiefs and the women working with me.

Now, at the end of this mission and as I am about to leave the atoll and the archipelago, it has become increasingly obvious to me that it is not the islands but the men on the islands, both chiefs and subchiefs, and the women and the tribesmen, who make the existence profitable, helpful, friendly—or dangerous, violent, angry or vicious. It is my feeling that without belief in the Order into which one has been inducted, very little constructive work can be done. With belief in the Order and faith in the mission, the opportunities for growth and service are endless; but the latter is usually limited to one's own island or to a relatively small area of influence. But then one might say, why should it be greater?

Naval Medical Research Institute
Bethesda 14, Maryland



WEBSTER BOYDEN, M.D.

The President's Page

"If there is any group of doctors under the American flag who should be most grateful for their professional training, it will be our group in the Territory of Hawaii, because we do not have a medical school here. In fact, most of us obtained such education from the mainland's state and private medical schools. Because of our humble success in our chosen field there is no better way to express our gratitude to these institutions than by annual donations to:

(1) The American Medical Education Foundation.

(2) Our respective medical schools direct."

The above is a quotation from a letter from Dr. Min Hin Li, Chairman of the Committee for Contributions to A.M.E.F. Contributions are of course solicited also from those who came to Hawaii from the mainland U.S.A. as well as those from foreign countries. Medical schools have increased their tuition in recent years in an attempt to meet increased costs but they need additional help if Federal intervention is to be averted or at least held to a minimum.

The following should be understood: If a physician sends in a check to a state or private university or college which has a medical department, the contribution will be distributed for the general use of the whole school unless clearly earmarked for the medical department alone. If the donation is made to an alumni association, again it should be designated for the medical department. Also state that you wish the A.M.E.F. to be notified of your contribution. If the check is mailed to the A.M.E.F., you should specify either a particular medical school or general distribution for medical education.

One department where assistance is especially needed is the faculty, where instructors are commonly underpaid. To implement the changing concepts of teaching medicine, larger faculties are required, and this in turn requires a still larger salary budget. A contribution to A.M.E.F., besides helping repay in part an obligation to our medical schools, is in line with a growing national belief that students with interest and ability in the sciences should have adequate opportunities to fully develop their talents.

W. Boyden

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[EDITORIALS]

Social Service— A Hospital Responsibility

Reluctance to accept help from social service workers in the care of patients has been strangely prevalent among physicians in many American communities, including ours, and many hospitals have been correspondingly and understandably reluctant to maintain adequate departments of medical social service. Miss Catton's article elsewhere in this issue[1] outlines the background of this problem as it pertains to The Queen's Hospital.

Some of the reasons for this attitude are suggested in an article by Eileen Blackey,[2] formerly on the sociology faculty of the University of Hawaii, helping to establish a school of social work, later with the V.A., and now a doctoral student in the School of Applied Social Sciences at Western Reserve.

Social work, Miss Blackey points out, has long been identified with economic distress and social reform, whereas the medical profession is overwhelmingly conservative in its views. Not only does the liberal philosophy of the social worker tend to clash with the conservative philosophy of the doctors; the social workers, says Miss Blackey, symbolize the conscience of the community, and "by their very presence arouse the guilt which all of us carry with regard to the suffering of our fellow men."

Many doctors naively suppose that social workers have no more to offer them than advice regarding the patient's financial resources. Possibly, as Miss Blackey suggests, many such doctors are fearful of encroachment upon their professional prerogatives, and would reject, emotionally, services that went beyond the scope of a financial investigation.

No physician in this day and age can fail to realize that "man's reaction to man"—the social and emotional factor, that is—is vitally important in causing and aggravating disease. Few have the time, even if they have the skill, to adequately explore this aspect of their patients' illnesses. Few residents, and fewer interns, know how to go about taking a social history.

True, this is not often essential to successful treatment. Neither is an adequate history, or a complete physical examination, or a blood count or urinalysis. We do not on this account forgo those procedures. An adequate social history may be far more significant and helpful than all the laboratory tests put together.

We do not suggest that social service investigations be made on every hospital admission, or even on most of them. We do suggest that such investigations should be made available for every patient in whom the physician thinks they might be helpful.

We also suggest that interns and residents are not being adequately trained to practice medicine unless they are given some guidance in the evaluation of social situations in relation to disease. Physicians are simply not competent to give them this training.

A strong Medical Social Service Department, under the guidance of an Advisory Committee of physicians, nurses, hospital administrators and other professional or lay persons, is a responsibility of every hospital. It is not likely to come about—nor would it be able to function adequately—without the support of the medical profession. Let us see to it that such support is forthcoming!

[1] Catton, M. M. L.: Medical Social Service: Discontinuance or Reorganization? HAWAII MED. J. 16:259 (Jan.-Feb.) 1956.

[2] Blackey, E.: Social Work in the Hospital: A Sociological Approach, Social Work 1:43 (Apr.) 1956.

Medicare "Control"

Medicare—the Military Dependents' Medical Care Program—begins in Hawaii, as this is written, with the Hawaii Medical Association as the contracting agent and the Hawaii Medical Service Association as the fiscal agent. The fee schedule was drawn up by the Fee Adjustment Committee of the Honolulu County Medical Society and approved—with slight changes—by negotiations between the Hawaii Medical Association and the Department of Defense. On the whole, we set our own fees, and we agreed to abide by them for the duration of the contract.

During this first seven months' trial period, the plan covers only illnesses for which hospitalization is used, and only military or quasi-military dependents. The only dependents eligible are spouses and children. It is widely believed, however, that it will be extended in the future to cover office care, and other federal employees and their dependents.

Selection of HMSA as the fiscal agent was dictated by the refusal of the Department of Defense to accept either HMA or the Bureau of Medical Economics of the Honolulu County Medical Society in this capacity, on the ground that they lacked the necessary physical facilities and the financial reserves. It was postponed almost to the deadline day by the unwillingness of the Honolulu County delegates to name HMSA fiscal agent, as advised by HMA Council and the Board of Governors of the Honolulu County Medical Society—unwillingness arising largely from their personal convictions, though it was supported by a 17 to 14 vote of the County Society membership, at the meeting of September 4.

At a special meeting of the Honolulu County Society held November 28, Honolulu's delegates were instructed to name HMSA the fiscal agent. At the special delegates' meeting held for this purpose December 4, however, HMA's AMA Delegate advised the delegates that informed opinion among several mainland medical leaders was opposed to medical participation in any service type of insurance plan in which the doctors did not have a controlling vote. This information caused them to table a motion to name HMSA as the fiscal agent, and adjourn the meeting.

The same evening, at the annual meeting of the Honolulu County Medical Society, the AMA Delegate reported on this to the membership, who discussed it and then overwhelmingly reaffirmed their action of November 28, to instruct their delegates to name HMSA the fiscal agent for Medicare. This action was taken at a final special session of the House of Delegates, held during the meeting.

Tripler Army Hospital, which had made preparations to begin administration of the plan, agreed to print and issue the necessary forms as planned, and to relinquish their temporary fiscal agency for it to HMSA as soon as the contracts were signed with the Department of Defense.

Real "control" of this or any other service type of insurance plan rests, necessarily, with whoever pays the bills—in this case, the Federal Government. Neither the contracting agent (the Hawaii Medical Association) nor the fiscal agent (the HMSA) are in any position to dictate the terms of the contract, except by negotiation at the terminations of contract periods. The idea that the medical profession would somehow exercise a greater degree of control of the Medicare program if it either acted as its own fiscal agent, or controlled the fiscal agent, seems on the face of it to be an illusion. Whoever pays the piper, calls the tune.

Morever, the history of HMSA's dealings with the medical profession whose services it dispenses is on the whole highly reassuring. It has operated its plans, for the most part, efficiently and in accordance with the guidance and recommendations of the medical minority of its Board of Directors. It has earned, and still enjoys, the trust of the majority of Hawaii's physicians, as evidenced by the overwhelming vote of confidence in it by each of the component county medical societies in naming it fiscal agent for Medicare.

Nevertheless, we believe that the question of the desirability of medical control of service-type medical insurance programs deserves careful consideration. The AMA House of Delegates at the Seattle meeting urged the medical profession to "retain or regain responsibility for the formulation of medical policies" of service type plans. Dr. Donald Stubbs, a Trustee of the Blue Shield Commission, said last November 3 at the Chicago Conference of Blue Shield Plans, "if physician control in some areas is weak, the proper response is to draw the plan closer to the profession and not push it away."

Perhaps physicians have sufficient control of HMSA now; certainly they have a great deal. Perhaps they could operate HMSA more effectively if they had a controlling vote in it, though the Moore Committee thought it unlikely. These questions need discussion, and if possible answering—preferably before Medicare's initial seven months' trial ends, next June 30. Honolulu County Medical Society's Medical Care Plans Committee and HMSA's representatives should be able to give us the answers.

Tuberculosis Casefinding

Nearly a decade of tuberculosis casefinding surveys conducted by the Health Department has achieved wide acceptance for such programs among both patients and the medical profession.

The follow-up examination of cases picked up in these surveys, however, has on occasion been carried out by the Department's Bureau of Tuberculosis when it might perhaps better have been done by private physicians. This problem was explored last fall by a special committee of the Honolulu County Medical Society, consisting of three general practitioners, two radiologists, a cardiologist, a pediatrician and a hospital pathologist,* under the chairmanship of Dr. Robert Y. Katsuki.

The committee's orderly, thoughtful five-page report concluded with the following recommendations:

1. As related to the Bureau of Tuberculosis:
 a. A space should be provided on the initial survey registration card for the name of the private physician and a standard procedure be instituted of asking a simple direct question such as "May we have the name of your physician so that we may send him a report?" If there is any hesitation, show of animosity or objection to the question, this should be so noted.
 b. In every stage of follow-up, the patient should be reminded that he is free to consult his private physician.
 c. When a potentially tuberculous lesion is discovered, the private physician, if named, should be contacted and conferred with for subsequent procedures and follow-up.
 d. Lanakila should make every effort not to accept cases for non-tuberculous work-up. If during the work-up of a suspicious case, the lesion is considered to be non-tuberculous, the case should be referred to a private physician or clinic.
2. As related to the Private Practitioner and the Medical Society.
 a. Private physicians should refer cases to Lanakila for tuberculosis work-up only. It is recommended that they do Mantoux's on all cases before referring to Lanakila.
 b. A Medical Society Consultation Committee should be established to assist the Bureau of Tuberculosis and to create better liaison between the practicing physician and the Bureau. Such a committee should be composed of radiologists and internists, the number of members to be determined by the Medical Society.
 c. If a private physician is unable or unwilling to follow up cases properly, he should refer such cases to practicing physicians who are equipped and willing to do so or utilize Bureau facilities. If Bureau facilities are utilized, the private physicians should work in close cooperation with the Bureau.
 d. When non-tuberculous cases are turned over to private physicians, the physician should notify the Bureau of the outcome of such cases as a matter of courtesy.
 e. The method of referral as suggested by the Tuberculosis Case Finding Committee is not considered necessary.
3. Although other aspects of the Governmental practice of medicine were considered to be beyond the scope of this committee, and therefore not included in its deliberations, it is recommended that the Medical Society continue the investigation of all aspects of the Governmental practice of medicine by other committees.

This effort to define the role of government in one phase of preventive medicine and medical practice is praiseworthy. If there is undue encroachment of government into the domain of private medical practice, this is the way to find it out and stop it.

We must not lose sight, however, of the corollary to such an action. If the medical profession claims the right to investigate tuberculosis suspects, it must be able and willing to assume the responsibility for this as well—both morally, and as a matter of law. The Consultation Committee suggested by this report should acquaint itself with past performance in this regard, and should see to it that adequate follow-up of suspects is actually carried out. If the medical profession doesn't do this job well, it will forfeit the right to do it at all.

* Special Public Health Survey Committee: Drs. Robert Y. Katsuki, Homer M. Izumi, A. Leslie Vasconcellos, George Henry, P. S. Arthur, A. S. Hartwell, John Kometani, and Raid Chappell.

Give to your Medical School—
not direct, but through the A.M.E.F.—
during 1957!

This is What's New!

Workers at a medical school in the foggy end of San Francisco advise clinicians to take advantage of the **diurnal variation in adrenal cortex secretion.** When your patient is pounding the pillow between midnight and the early morning hours, the adrenal is secreting at a maximum level in anticipation of the rigors of the coming day. The administration of say 10 mg of prednisolone in **one dose at 8:00 a.m.** merely adds on to this normal production of corticoids and causes practically **no depression** of the now resting adrenals. The same dose given at the end of the day would merely suppress the rising adrenal activity during the night and would have very little therapeutic effect. This basic day-night cycle is upset by emotional stresses and painful stimuli, but not by sleep habits, visual impulses or food intake. Ten mg of prednisolone given in one dose at 8:00 A.M. may be even more effective than 10 mg given every six hours over a period of 24 hours. *Am. J. Med.* (Sept.) 1956.

* * *

The fantastic business of temporarily replacing the human heart and lung with a mechanical apparatus while defects within the heart are being repaired is becoming an almost everyday procedure. The group at University of Minnesota Medical School now reports some 80 patients undergoing **total heart-lung by-pass** for as long as 25 minutes or so while various heart defects were corrected. Blood is collected from the superior and inferior vena cava by means of tubes and pumped into an oxygenator. The oxygenated blood is then pumped back into the aorta via a long plastic tube in the femoral artery. This and other types of heart-lung shunts are described in November, 1956, issue of the *Journal of Thoracic Surgery,* which of necessity is reading more and more like a physiological journal these days.

* * *

Radioactive antitubercular drugs are being used in Chicago in an attempt to learn how and where such drugs as INH, PAS and streptomycin work. Both INH and PAS have been tagged with radioactive carbon. The tagged **INH spreads widely throughout the entire body,** with persistent concentration in lungs, adrenals, liver, and skin. In short, it stays longest where needed most. Not only does the radioactive INH have a capacity to penetrate scarred tubercles, but it actually accumulates in them! The drug also **penetrates the meninges** with no difficulty, which helps explain the fact that patients on INH practically never develop tubercular meningitis. Tracer studies with PAS and streptomycin have been delayed because of the difficulty of incorporating carbon 14 into these molecules, but chemists have recently succeeded in accomplishing this in the case of PAS and further experiments are now under way. *Scientific American* (Nov.) 1956.

* * *

An Associate Professor of Medicine at Johns Hopkins takes a gentle dig at Drs. Ancel Keyes and Bronte-Stewart who with Dr. Paul White recently visited Hawaii. She starts her article: "To be fashionable in the field of cholesterol today one should either have a giant centrifuge, or travel." Her investigations did not involve studies on the Bantus, Eskimoes, Norwegians or Japanese or even Hawaiians, but were limited to medical students at Johns Hopkins over a 10-year period. Nearly **one out of ten** of these young students in their early twenties had asymptomatic **hypercholesteremia of over 300 mg per cent.** There was an extremely strong **familial tendency to cardiovascular disease,** especially coronary disease, as well as diabetes, in the students with high cholesterols. This elevated cholesterol makes its appearance when physical growth and sexual maturity are complete. *Am. J. Med. Sci.* (Oct.) 1956.

* * *

Dr. Sarah Luse of Washington University School of Medicine teamed up with an electron microscope to take some of the most exciting "photographs" of the year. She has shown that in **multiple sclerosis** it is not the myelin which degenerates, but rather the **glial cells that produce the myelin** which undergo degeneration. This is one of the most important clues as to the cause of this disabling disease to be uncovered in the past century. It shifts the research from focusing entirely

(*Continued on page 320*)

Perhaps It's Your Nerves

Berserkers, Bufoes, and Mushrooms

The fierce Viking warriors known as Berserkers and the giant toad called Bufo are linked through an indole compound, n-n-methyl serotonin or bufotenine. This psychosis-producing substance occurs in the skin of the toad, and also in the fly-agaric mushroom, Amanita muscaria, which the Viking warriors are suspected of having eaten before their periodic outbursts of fury known as *Berserksgang*.

Charles Kingsley tells in *Hereward the Wake* how Hereward went out to do battle "baresark," i.e., wearing only a shirt. A shirt of bearskin, or *ber sark*, was the customary fighting garb of a mythical Norse hero known as Berserk, renowned for his courage and the fury of his attack in battle. A thousand years ago in Scandinavia his name was given to various groups of murdering ruffians or hoodlums who went on periodic predatory forays against their own people.

Howard Fabing of Cincinnati reviews[1] the historical and contemporary neurochemical evidence for the widely held belief that these berserkers, as they were called, deliberately inflamed themselves by eating poisonous mushrooms, probably Amanita muscaria, in preparation for these savage outbursts. He finds it, on the whole, plausible.

The Koryaks of the Kamchatka peninsula have been known for over two hundred years to indulge in the orgiastic eating of Amanita muscaria. The neurotoxic principle is rapidly excreted in the urine, which it is their practice to drink in order not to waste it: a man may drink his own urine to prolong his psychosis, or that of others in order to re-use the essence of the mushrooms they have eaten. The hallucinogenic effect of one dose of mushrooms can thus be passed successively to as many as five individuals.

The effective principle in the mushrooms is not yet known. It is known, however, that they contain bufotenine. Experiments with the effect of this drug on volunteers have produced symptoms which correspond very closely to old descriptions of the behavior and appearance of the berserkers, short of the actual murderous rage described in them.

Hallucinations, confusion, lightheadedness, restlessness, and a singular empurpling of the face occurred in all subjects in varying degrees, and the old Norse accounts stress the "swelling and change of color" of the face of berserkers during their rages. Fabing says the faces of the subjects were comparable only to a dilution of the color of the skin of an eggplant.

Modern pharmacology seems to have tentatively confirmed, then, this almost two centuries old explanation of a remarkable and unique ethnic practice, in terms of what is known today as a "model psychosis," akin to the reactions produced by mescaline and LSD-25 (lysergic acid diethylamide). Further studies now in progress at the National Institutes of Health may throw further light on the active principles in Amanita muscaria, other than bufotenine.

HARRY L. ARNOLD, JR., M.D.

[1] Fabing, H. D.: On Going Berserk: a Neurochemical Inquiry, Am. J. Psychiatry 113:409 (Nov.) 1956.

Umi Makahiki I Hala*

Year's Residence Clause Approved

By a vote of 154 to 96, the members of the Hawaii Territorial Medical Association voted against the repeal of the one-year residence requirement for medical licensure by the forthcoming session of the Legislature. Approximately 100 members refrained from voting.

Three new members were welcomed into the Society: **Dr. A. Leslie Vasconcellos, Dr. Ralph S. Steffe** (by transfer from Washtenaw County, Michigan), and **Dr. Wayne Wong** (by transfer from Cook County, Illinois).

Dr. Clarence E. Fronk, of Honolulu, has returned from his safari in Africa and reports in glowing terms his experiences there. On his return he addressed a meeting of the Western Surgical Society, in Memphis, Tennessee, on diseases peculiar to the natives of East Africa.

Dr. Edward F. Cushnie, of Honolulu, is now located in the Young Building, in association with **Drs. Henry S. Dickson** and **Edwin K. Chung-Hoon.** Prior to this he was associated with The Clinic.

* Ten years ago. From Volume 6, Number 3, January-February, 1947.

In Memoriam --- Doctors of Hawaii ---VI

This is the sixth installment of In Memoriam—Doctors of Hawaii.

Charles T. Rodgers

Charles T. Rodgers was born in New York City about 1836. He was educated in the schools of the same city and graduated in 1874 from the Medical Department of the University of New York.

While Dr. Rodgers was living in New York, he was prominent in politics, particularly during the years prior to the Civil War. On one occasion he was a member of the committee which welcomed Abraham Lincoln to New York and arranged for his address at Cooper Union.

In 1876 Dr. and Mrs. Rodgers came to the Islands to make Honolulu their home. Dr. Rodgers engaged in general practice, and during the epidemic of 1881 he was in charge of Quarantine Island and the smallpox hospital. From 1887 to 1890 he was physician to the Oahu prison and police surgeon.

Dr. Rodgers' talents were not confined to the field of medicine alone. During the absence of Henry Castle in 1889, Dr. Rodgers served as acting editor of *The Advertiser*. He was acting superintendent of the census of 1890 in Hawaii. His compilation was the first complete report in pamphlet form of any census taken here.

Carrying on his early interest in politics, Dr. Rodgers was secretary of the annexation committee and recorded all the minutes of those stirring meetings. Prior to that he was also secretary of the executive and advisory councils under the Provisional Government in 1893.

After retiring from active practice, the doctor became secretary to the Department of Public Instruction in 1896. He filled this position most creditably until 1905, when failing health compelled him to resign. He was also the author of many articles on educational matters.

Dr. Rodgers' name was most intimately connected with the founding and subsequent growth of the Honolulu Public Library. He remained a director of the library until his death.

Dr. Rodgers died April 24, 1912, in Honolulu at the age of 76.

He was probably the highest ranking Odd Fellow in the Hawaiian Islands, being past district deputy grand sire. He was a member of Harmony Lodge, Polynesia Encampment and Pacific Rebekahs.

The following is taken from the Proceedings of the Medical Society of Hawaii, 1912, and written by the Committee on Necrology consisting of Drs. St. D. G. Walters, C. B. Wood, and C. B. Cooper:

"Save in his physical powers, Dr. Rodgers never grew old: he was a well read man and kept abreast of the times to the last. To his friends there never appeared any perceptible clouding of his intellect with advancing years; he was a splendid conversationalist, a man of clean life and thought and speech; of a character dignified, worthy and amiable. He loved the monthly meeting of his medical society and was its most faithful attendant so long as he was able to be present.

"The manner of his going was touching. In the feebleness of his last days he was spared much suffering, and was even able to walk unaided from room to room the very last day of his life. In the evening he retired as usual, calm, peaceful, and even cheerful. The next morning upon his not appearing, he was found in his bed with eyelids closed apparently asleep but he was not breathing, and the tired heart had forever ceased to beat, a restful ending most befitting a long life full of hard work, of good deeds and helpful ministration to his fellowmen."

John Brodie

John Brodie was born in Canada on March 7, 1853. He graduated from McGill University at Montreal, Quebec. After graduation he visited great hospitals and medical schools in London, Paris and Germany.

Poor health brought Dr. Brodie to Honolulu about 1880. Going into partnership with Dr. Miner, who left shortly thereafter for Germany, Dr. Brodie assumed his practice.

His health being unequal to the pressure of work, he abandoned his town practice for a time and purchased Halemano Ranch near Waialua. There he built a beautiful residence and, as a country squire, lived a happy life.

The ranch proved to be non-paying and Dr. Brodie was obliged to sell and then moved to San Francisco, where he built up as successful a practice as he had had in Honolulu. However, the climate did not agree with him and he returned to Honolulu after a few years.

Again the demands on his services proved too great, and a severe illness forced him to leave the islands shortly after the cholera epidemic ended. He returned to Honolulu after six weeks, feeling better, but died shortly afterwards, on November 2, 1895, at the age of 42.

Albert Bradley Carter

Albert Bradley Carter was born in New York City, February 23, 1860.

He came to Honolulu in the early 80's, shortly after graduation from the College of Physicians and Surgeons.

Dr. Carter was a government physician for the district of Koolau and lived at Hauula until his last illness.

He was married and had a son, Thomas J. Carter.

Dr. Carter died on March 31, 1927, in Honolulu at the age of 67.

C. B. Greenfield

Dr. C. B. Greenfield, an Englishman, died at Honokaa, Hawaii, January 25, 1907, at the age of 63.

Little is known about Dr. Greenfield except that he practiced in Hamakua, Hawaii, between 1881 and 1890. In the sketch of Dr. Alexander Atherton, a Dr. Greenleaf of Hamakua is mentioned whose practice Dr. Atherton took over in September and October, 1901, while Dr. Greenleaf recovered from a broken leg. It

is very probable that Dr. Greenleaf and Dr. Greenfield are one and the same, early reporting not being noted for its accuracy where names were concerned.

Sarah Eliza Emerson

Sarah Eliza Emerson was born at New Bedford, Massachusetts, the daughter of Capt. Abraham W. Pierce.

She came to the Islands with her mother as a baby, sailing around the Horn in a whaleship under her father's command.

Her girlhood was spent at Fall River, Massachusetts. Later she came again to the Islands and studied at Punahou.

Sarah became one of the pioneer Massachusetts women to study medicine at the Homeopathic College, since Boston Medical School would not accept women at that time.

After graduation, Dr. Pierce continued her medical studies abroad, serving as intern in Paris and Dresden. She specialized in obstetrics.

Dr. Pierce practiced medicine in Honolulu before her marriage to Dr. Nathaniel Emerson in 1881. One son, Arthur E. Emerson, was born to the couple.

Dr. Emerson was a member of the board of examiners for an insane asylum, and treasurer for Central Union Church.

On October 30, 1938, Dr. Emerson died in Honolulu at the age of 86.

St. David Gynlais Walters

St. David Gynlais Walters was born March 1, 1856, at Ystradgynlais, Brecknockshire, South Wales, the son of Thomas and Caroline (Rees) Walters.

He was educated at Gloucester and Hereford Cathedral schools from 1864 to 1874. Attending St. John's College at Cambridge from 1874 to 1879, he received his B.A. with honors. Dr. Walters was also granted his L.R.C.P., L.R.C.S., and L.M. Edinburgh.

The young doctor began his professional career with Dr. J. Dellett Smith in Liverpool in 1881. He also served during that year as senior resident medical officer at Brownlow Hill Hospital and as house surgeon at Stanley Hospital, Liverpool.

In 1882 Dr. Walters became surgeon aboard the S.S. "Monarch" and in the same year arrived in Hawaii. He held the position of government physician at Lihue, Kauai, from 1882 to 1897, following which he entered private practice in Honolulu. He was associated with Dr. George Herbert and later was joined by Dr. G. C. Batten. In 1902 he was medical superintendent of the Oahu Insane Asylum.

On January 30, 1895, Dr. Walters married Severina Lucy Herbert in Honolulu.

Dr. Walters was the first to discover beriberi in the Hawaiian Islands in 1882 and also dengue in 1902. He was the author of *The Examination of the Heart an Exact Science.*

From 1900 until he retired, he was an honorary physician and surgeon on The Queen's Hospital staff and also at Children's Hospital.

Retiring from active practice in 1920, Dr. Walters went to San Francisco where he died on August 20, 1932, at the age of 76.

He was a member of the Bohemian Club of San Francisco, the Pacific Club (president 1917), a charter member of the University Club, a charter member of the Oahu Country Club, Fellow of the American Medical Association, Hawaii Territorial Medical Society (president 1910), and Honolulu County Medical Society.

Oscarus Samuel Cummings

Oscarus Samuel Cummings died at Vadesta, Georgia, on February 17, 1883, at the age of 35.

Benjamin Davis Bond

Benjamin Davis Bond was born at Kohala, Hawaii, on January 21, 1853. He was the son of the Rev. Elias and Ellen Mariner (Howell) Bond, noted missionaries.

His education was received at Punahou Academy, Honolulu, and at Phillips Exeter Academy, New Hampshire. In 1879 he obtained his B.A. from Amherst College. His medical degree was granted by the medical college of the University of Michigan in 1882. He took postgraduate work in New York City.

It was Dr. Bond's desire to be a medical missionary in India, but the great need of a physician understanding local conditions brought him back to his birthplace in 1883 to begin his practice.

On September 5, 1889, Dr. Bond married Emma Mary Renton at Kohala. They had four children, Benjamin Howell, Alice Renton, Kenneth Davis, and James Douglass Bond.

Dr. Bond was the only medical man within a radius of from 30 to 40 miles at a time when all traveling was done on horseback. Added to this, he was the only doctor retained by five plantations. Dr. Bond was also resident government physician and acting assistant surgeon for the U. S. Public Health Service at Mahukona, Hawaii.

In 1923 he retired, and in 1928 the family moved to Hilo.

Dr. Bond was a great nature lover. He always carried seeds in his pocket wherever he went to scatter along the way. It is said that he was the first to introduce the white ginger, known as the common wild ginger.

Dr. Bond died November 2, 1930, at Hilo at the age of 77.

He was a member of the Sons of the American Revolution, American Medical Association, Medical Society of Hawaii, Hilo Yacht Club, and the Hilo Chamber of Commerce.

Arthur A. St. Maur Mouritz

Arthur A. St. Maur Mouritz was born in London, England in 1855.

He began his medical studies at the age of 16 at Oxford University. He also attended Cambridge and the Paris Academy, where he worked under the great neurologist, Charcot.

Completing his education, he was given the rank of second lieutenant in the British Navy and sent to Africa to assist in stamping out malaria. After finishing his work in Africa, Dr. Mouritz was for two years ship's surgeon on sailing clippers and steamers of the Dutch India Company on the South American run.

In 1883 Dr. Mouritz came to Hawaii as ship's physician on the steamer, "Aberfeldie," on which there were a large number of Portuguese also bound for Hawaii. He decided to remain and make Hawaii his home. Shortly after his arrival King Kalakaua requested that he take a stricken English ship, which had arrived from

(*Continued on page 318*)

The Honolulu County Medical Library

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Recent Acquisitions

Cardiovascular System

Brecher, G. A. *Venous return.* c1956. (gift of publisher)

Friedberg, C. K. *Diseases of the heart.* 2nd ed. c1956. (gift of publisher)

Diagnosis

Forkner, C. E., ed. *Practitioner's conferences.* v.4. c1956. (gift of publisher)

Levinson, S. A. *Clinical laboratory diagnosis.* 5th ed. rev. c1956. (gift of publisher)

Merck manual of diagnosis and therapy. 9th ed. c1956. (gift of publisher)

Endocrinology

Jackson, Henry *Hodgkin's disease and allied disorders.* c1947. (gift of Dr. Marie Faus)

Wolstenholme, G. E. W., ed. *Ciba Foundation colloquia on endocrinology.* v.5-9, c1953-56. (gift of Ciba Foundation)

Geriatrics

Homburger, Freddy *The medical care of the aged and chronically ill.* c1955. (gift of Dr. Marie Faus)

Gynecology

Schauffler, G. C. *Pediatric gynecology.* c1942. (gift of Dr. Marie Faus)

Thoms, Herbert *Pelvimetry.* c1956. (gift of publisher)

Infectious Diseases

Blank, Harvey *Viral and rickettsial diseases of the skin. eye and mucous membranes of man.* c1955.

Lungs

Kraetzer, A. F. *Procedure in examination of the lungs.* 3rd ed. rev. c1947. (gift of Dr. Marie Faus)

Simons, E. J. *Primary carcinoma of the lung.* c1937. (gift of Dr. Marie Faus)

Laboratory Technique

Wolstenholme, G. E. W., ed. *Ciba Foundation symposium on paper electrophoresis.* 1956. (gift of publisher)

Medicine

Clendening, Logan *The romance of medicine.* c1933. (gift of Dr. Marie Faus)

Da Costa, J. C. *Selections from the papers and speeches . . .* c1931. (gift)

Snapper, I. *Meditations on medicine and medical education.* c1956. (gift of publisher)

Stevenson, G. S., ed. *Administrative medicine. Trans. . . . 4th conf., Oct. 31-Nov. 2, 1955.* c1956. (gift of Josiah Macy, Jr. Foundation)

Neurology and Psychiatry

Getz, Steven *Environment and the deaf child.* c1953. (gift of publisher)

Nachmansohn, David, ed. *Nerve impulse. Trans. . . . 5th conf. Sept. 20-22, 1954.* c1956. (gift of Josiah Macy, Jr. Foundation)

Nyswander, Marie *The drug addict as a patient.* c1956. (gift of publisher)

McCord, William *Psychopathy and delinquency.* c1956. (gift of publisher)

Piers, Gerhart *Shame and guilt.* c1953. (gift of publisher)

Schaffner, Bertram, ed. *Group processes. Trans. . . 2nd conf., Oct. 9-12, 1955.* c1956. (gift of Josiah Macy, Jr. Foundation)

Tulane Dept. of Psychiatry and Neurology *Studies in schizophrenia.* c1954. (gift of Dr. Marie Faus)

Nursing

Chaffee, E. E. *Laboratory manual in physiology and anatomy.* c1956. (from Nurses' Association)

Cooper, A. M. *How to supervise people.* 3rd ed. c1952. (from Nurses' Association)

Cowan, M. C., ed. *The yearbook of modern nursing. 1956.* c1956. (from Nurses' Association)

Gutierrez-Mahoney, C. G. de *Neurological and neurosurgical nursing.* 2nd ed. c1956. (from Nurses' Association)

Jamieson, E. M. *History of nursing notebook.* c1956. (from Nurses' Association)

Marshall, John *Neurological nursing.* c1956. (gift of publisher)

Sommermeyer, Lucille *Laboratory manual and workbook in microbiology.* c1956. (from Nurses' Association)

Ophthalmology

Newell, F. W., ed. *Glaucoma. Trans. . . 1st conf., Dec. 5-7, 1955.* c1956. (gift of Josiah Macy, Jr. Foundation)

Wolff, Eugene *A pathology of the eye.* 3rd ed. 1951.

Orthopedics

Hackett, G. S. *Joint ligament relaxation treated by fibro-osseous proliferation.* c1956. (gift of publisher)

Kitay, William *New facts about bursitis.* c1953. (gift of Dr. Marie Faus)

Wolstenholme, G. E. W., ed. *Ciba Foundation symposium on bone structure and metabolism.* 1956. (gift of publisher)

Pathology

Wells, B. B. *Clinical pathology.* 2nd ed. c1956. (gift of publisher)

Respiratory System

Hinshaw, H. C. *Diseases of the chest.* c1956. (gift of publisher)

Roentgenology

Caffey, John *Pediatric x-ray diagnosis.* 3rd ed. c1956.

(*Continued on page 337*)

Book Reviews

A Pictorial History of Medicine.

By Otto L. Bettmann, M.D., 318 pp., Price $9.50, Charles C. Thomas, 1956.

In order to write a truly pictorial history of medicine, Dr. Bettmann has spent thirty years searching through the libraries and picture galleries of the world.

By following the principle that one picture is worth a thousand words, he has been able in one volume to review the whole development of the healing art for the last five thousand years.

The text is compact, written in a good literary style, easy to read, and enlivened by a well applied humorous twist wherever the occasion permits.

The author parades before us the ups and downs of medicine, the professional and lay people who have furthered or retarded it, the students and quacks, the giants and dwarfs.

His book brings us up to the beginning of chemotherapy or the early twentieth century.

It is difficult to say whether Dr. Bettmann is reserving the last fifty years of medicine for another volume, thinking that, perhaps, that span of time contains as much in progress as the past fifty centuries, or whether he considers the advance of our period as a matter of news rather than of history.

MAURICE GORDON, M.D.

Synopsis of Gynecology.

By Robert J. Crossen, M.D., Fourth Edition, 255 pp., illustrated, Price $5.25, C. V. Mosby Company, 1956.

The small volume of the "Synopsis" has been revised with particular attention to oogenesis and ovarian function concomitant, and the endometrial changes. Techniques have been brought up to date.

It is well printed, with good illustrations, on glossy paper.

Dr. Willard Allen's section on "Endocrine Relations Concerned in the Ovarian Cycle" and Dr. A. N. Arneson's section on "Radiation Therapy" are excellent abstracts of the same sections from the author's "Diseases of Women."

It is an excellent manual for medical students but may be too sketchy to interest the general practitioner.

ROBERT G. HUNTER, M.D.

Blakiston's New Gould Medical Dictionary.

Edited by Normand L. Hoerr, M.D. and Arthur Osol, Ph.D., 1,463 pp., (2nd Edition), illustrated, Price $11.50, Blakiston Division, McGraw-Hill Book Company, Inc., 1956.

It is rather difficult for me to convey an impression of enthusiasm and spontaneous delight while poring over a volume wholly devoted to the defining of terms encountered in the field of medicine and kindred branches, and containing such collateral information as medical men generally would be likely to look for.

As I thumbed through this word-book, I became impressed with the manner of wording of definitions, which are clear, concise and yet complete. I will have to admit to several satisfying interludes with copies of *Life* and *Esquire* during the period of time allotted for this project.

The book does not claim to be an encyclopedia; it is a dictionary. Careful selection of vocabulary entries has continued in this second edition. Professional literature has been studied for new words to be defined through the efforts of an editorial board and eighty-eight contributors.

A special effort has been made to produce a volume of attractive appearance and convenient size such as a man would want to keep on his desk for constant reference. By use of a large page with a compact but clear typography it has been possible to furnish an unusually large amount of matter in a volume of handy size.

RALPH M. BEDDOW, M.D.

Venous Return.

By Gerhard A. Brecher, M.D., 148 pp., illustrated, Price $6.75, Grune & Stratton.

This monograph is clearly written and authoritative. Controversial experimental data are presented clearly and completely followed by a short summary at the end of each chapter on the major points of agreement and disagreement.

The book is not recommended for the general practitioner. It would be of some value to thoracic surgeons, anesthesiologists, and to a wider extent, cardiologists. It would be of greatest value to those doing circulatory physiology.

BERNARD W. D. FONG, M.D.

Treatment of Heart Disease.

By Harry Gross, M.D., 549 pp., illustrated, Price $13.00, W. B. Saunders & Co., 1956.

The authors state that theirs is a clinical physiologic approach to the treatment of heart disease, and accomplish their objective very well. Explaining the "whys" in cardiac therapy without lengthy and detailed physiologic explanations makes the text very easy to read. A thorough review of the different methods of treatment of each condition is discussed. From this, the authors state which method has given best results from their experience. The summary which follows each chapter presents the subject in a nutshell. There was no difficulty reading this book from cover to cover and I strongly recommend it to any physician interested in the treatment of heart disease.

CHEW MUNG LUM, M.D.

Practitioners Conferences, Vol. 4.

Edited by Claude E. Forkner, M.D., 407 pp., Price $6.75, Appleton-Century-Crofts, Inc., 1956.

Panel discussions have gained increasing popularity as a comprehensive as well as entertaining medium for medical education. This is particularly true when the participants are as able and well-qualified as those presented in these conferences. The subject matter is varied and of interest to specialists as well as general practitioners.

T. F. FUJIWARA, M.D.

(Continued on page 340)

HMSA—Its Place in the Community

Report of HMSA Medical Committee*

By the end of 1956 membership in HMSA will exceed 145,000, which means that practically one out of every four individuals in the community is enrolled in HMSA. There will be approximately a net gain of 40,000 members in 1956. The largest enrollment came from members of the Hawaiian Government Employees Association (HGEA) and the non-bargaining employees of the pineapple industry. The large HMSA membership indicates the rapidly growing interest of the public in a voluntary method of budgeting for medical expenses. To the doctors, this large enrollment and a continued increase in membership means more guaranteed dollars for professional services rendered to the people in the community.

In 1956 HMSA expected to pay over THREE MILLION FIVE HUNDRED THOUSAND DOLLARS ($3,500,000.00) to doctors and hospitals for services rendered. Two and one third million dollars ($2,330,000.00) of this amount will be payments made to physicians. Significantly, practically all monies paid by HMSA for services remain right in the Territory of Hawaii, thereby making HMSA a large financial factor in the community. Between January and November of 1956 the Medical Committee approved 331 combined medical-hospital claims over $500.00 each for a total payment of $239,805.00. Fifteen such claims exceeded $1,200.00 for doctor and hospital services.

Among recommendations of the Medical Committee for Plan improvements were:

1. **Fee Adjustment.** As a result of favorable operations during 1955, HMSA was able to effect adjustments in the Fee Schedule on October 1 totalling $50,000.00 per annum. This adjustment was based on changes suggested by individual physicians from time to time to the HMSA Medical Director, who forwards them to the Fee Adjustment Committee of the Honolulu County Medical Society for review and consideration.

2. **Medical Consultation.** HMSA increased the allowance for a medical consultation under the Community Group Medical Plan to equal the allowance for a surgical consultation.

3. **Two Physicians.** The administrative rule regarding division of a surgical fee when more than one physician has attended the patient was revised. Under the revised ruling, the two physicians will determine an equitable settlement of the HMSA allowance and each will bill HMSA for his portion of the fee.

4. **The 1% Deduction.** This deduction from each physician's claim was dispensed with for the remainder of the calendar year, effective October 1, 1956, as an adequate sum had been deducted to share the expense of the office of the HMSA Medical Director during the first nine months of the year.

5. **Unfavorable Claims Experience.** The Medical Committee referred claims experience of two Oahu physicians to the Honolulu County Medical Society for review and necessary action. One case was settled by the Medical Practice Committee and the other was referred to the Board of Censors for further review. It is the Committee's opinion that referral of this type of case to the Medical Society is in the best interest of all physicians and is necessary to assure sound financial operation of the plan.

6. **Community Group Medical Plan.** In spite of the apparent success of the plan, complaints emanated from the medical profession, particularly among non-participating physicians. The chief complaints concerned the method of settling claims of non-participating physicians and the high income limits of $7,500.00 and $10,000.00. All problems relative to the Community Group Medical Plan were referred to a special committee of the Honolulu County Medical Society, the Medical Care Plans Committee. This committee is currently reviewing the various phases of the plan with HMSA and final results of this study will be forthcoming. The comprehensive coverage which the Community Group Medical Plan offers seems to meet the public's demand for medical plan coverage.

7. **Major Medical Expense.** As a further step of progress, HMSA has revised its Major Medical Expense coverage effective December 1, 1956. This "rider" offers supplementary coverage for catastrophic illnesses up to a maximum of $10,000.00 together with many important benefit adjustments. In addition, rates will be less than the current Major Medical Expense Rider. With a basic plan like the Community Group Medical Plan and the Major Medical Expense Rider, HMSA will be one of the most progressive Blue Shield Plans available anywhere in the country today.

8. **Mainland Conferences.** Dr. Marvin A. Brennecke of Kauai represented HMSA at the Annual Blue Shield-Blue Cross conference in Hollywood, Florida, on April 8-12, 1956, and Dr. Toru Nishigaya attended the Western Regional Conference of Blue Shield Medical Care Plans in Sun Valley, Idaho, on October 10-14, 1956.

(*Continued on page 333*)

* Report presented at the annual meeting of the Honolulu County Medical Society, December 4, 1956.

Bureau of Medical Economics

Consultation Fees ? ? ?

Dr. Stanley R. Truman, in his book *The Doctor,* wrote: "The most common criticism of the medical profession is that the physician does not explain the patient's illness to him." After three years of dealing with past due accounts we here in the Bureau have come to the conclusion that the patient's second most common criticism of the medical profession is that the physician does not explain the role of a consultant.

Time after time we have talked to patients who did not even realize a consultant had been called in. In most cases the patient had not been made to understand the role a consultant plays or the ethical relationship between an attending physician and a consultant.

The standard gripe goes something like this: "I paid my own doctor's bill, why should I pay a bill for a consultant? Why, he didn't spend more than five minutes with me and I haven't seen or heard from him since. Then all of a sudden I get a bill for $10.00, and for what? Five minutes of his time! If he needs money that badly, then tell him to get it from my family doctor. I've already paid him." (Usually he hasn't.)

Now what has really happened in this case? First, it becomes obvious that the attending physician did not explain to the patient that he (the patient) was engaging the consultant and that he (the patient) was to pay the consultant's fee. Second, and again it is obvious that the patient did not realize that the consultant was not called in until the history, physical examination, laboratory and x-ray examinations were completed, the patient did not understand that the consultant was not there to help the patient directly but to help the patient through helping the attending physician.

Another type of case is where the patient gladly pays the consultant's fee but is up in arms about the attending physician's sending a bill. It goes something like this: "These doctors have a racket! What happens? I go to one doctor and he can't find out what is wrong and so he sends me to another doctor. The second doctor fixes me up and the first doctor wants to charge me for it. How about that gall?"

In this case it appears that the consultant made no attempt to make the patient realize that he was working through the attending physician. James E. Bryan in his book *Public Relations in Medical Practice* wrote as follows: "Primarily the consultant must bear in mind that he is called in to work through the physician in charge. Anyone who remains conscious of this will not be guilty of usurping the stage. The ideal consultant, in fact, will go out of his way to keep the physician in charge very much in the picture. When his part has been accomplished, the consultant will even say a few words to those concerned to show that he intends to leave the patient in the capable hands of his colleague."

I feel that this is one area of criticism that can be easily avoided and another fee complaint that is based on the doctor's failure to explain his services, rather than the size of the fee, can be eliminated.

The Bureau Recommends:

That the patient first be informed why a consultant is being called in. Dr. Stanley Truman wrote as follows which seems appropriate:

"How does one suggest to the patient or family that a consultation is desired, without alarming them or implying professional insufficiency? Usually this is easy, and the situation usually supplies the means; however, I have found that a little speech which sounds something like this seems to run off rather smoothly: 'When you have a difficult decision, or unusual problem, or serious responsibility, you want to talk it over with someone. I always like to do this too. I know that you have confidence in me and in my reputation as a doctor, but I am human, and being human I could make a mistake. I know that I don't know everything, and I like to share serious responsibilities with someone. I consider the diagnosis and treatment of your illness a serious responsibility; and as I would appreciate the opportunity to talk it over with another doctor, I am sure that you will be glad to have me call someone in for consultation.' It is easy to expand on such a theme as this, making it fit any situation."

Next the patient should fully understand the role the consultant will play. Dr. Truman feels that a consultant should be suggested by the doctor, rather than by the patient. Nevertheless, regardless of who initiates the matter, the attending physician should make certain that the patient understands that he has engaged the consultant, that he is to pay the consulant's fee, that the consultant is being called for the welfare of the patient, *but will help the patient only by advising the attending physician as to the patient's welfare.* Above all be certain that the patient understands that the consult-

(*Continued on page 330*)

a highlight in therapeutics

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Spontaneously acknowledged by physicians everywhere as an outstanding therapeutic advance, repeatedly confirmed during more than three years of clinical usage, ACHROMYCIN* Tetracycline ranks among the foremost in its field today... judged on its exceptional effectiveness against a wide range of pathogens, prompt control of infections most commonly encountered in medical practice, low incidence of side reactions, minimal emergence of resistance.

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Woman's Auxiliary

Hawaii County

The quarterly meeting of the Hawaii Medical Auxiliary was preceded by cocktails and dinner with the Medical Association at the Hilo Yacht Club, Thursday, December 6. After the guests had enjoyed a delicious steak repast, The Gleemen entertained with many choral selections, several of which were specially related to the Christmas season.

A regular business meeting of the auxiliary members was then conducted on the lanai by their president, Mrs. Archie Orenstein. There was discussion about a Christmas treat for some ill or less fortunate group. It was decided to contact the nurse in charge of the children's ward at Hilo Memorial Hospital and to make a suitable contribution for the pleasure of these patients. Flowers for Hilo Memorial Hospital will continue to be supplied by auxiliary members and a schedule for the next year will be arranged.

The annual official visit of the W.A.H.M.A. president, Mrs. Edmund Tompkins, was made to this meeting.

Mrs. William Bergin will serve as nominating committee chairman. Election of officers will be at the annual meeting in March.

Honolulu County

Old English hot punch, served with holiday cookies, highlighted the December 5 meeting of the Honolulu County Auxiliary at the Tantalus home of Mrs. Howard Liljestrand. Besides these culinary delights, the auxiliary members enjoyed a demonstration of "how to do it" and a display of Christmas decorations by Mrs. Francis Bower. This occasion was also a special welcome to the 49 doctors' wives who have joined the auxiliary for the first time during the past year.

Current projects of auxiliary members have been helping stuff TB Christmas seal envelopes and helping stuff Dreypaks for the Diabetic Detection Drive.

New committees will be A.M.E.F., a standing committee, and Mental Health, a special committee.

Mrs. Nils Larsen will be chairman of women's activities in connection with the Allergists' post-convention in February.

SPECIAL! A $200 contribution to the American Medical Education Foundation was authorized.

Maui County

Maui Auxiliary enjoyed dinner and a social evening at the new home of Dr. and Mrs. Seiya Ohata on the beach at lower Paia, November 12. Co-hostesses were Mrs. R. J. McArthur and Mrs. Mamoru Tofukuji. Mrs. David Rytand was the guest of the doctors' wives while Dr. Rytand spoke to the medical association. It was announced that the Maui County Medical Society wishes the auxiliary to continue promoting *Today's Health* subscriptions and to accept A.M.E.F. as a project, but not to participate in a program concerning mental health.

Mrs. Robert Cole was appointed chairman of the "In Memoriam" committee and Mrs. Joseph Ferkany was asked to prepare procedure books for each officer.

Executive Board

The mid-year Executive Board meeting of the W.A.H.M.A. was held November 30, that windy, rainy Friday.

Extensive consideration was given the proposed budget and suggestions noted to provide for all expenses throughout the fiscal year.

A report was made of the recommendations of the Advisory Committee for auxiliary projects, and the president informed the board that the question of who should set the policy of what doctors are to be included in "In Memoriam-Doctors of Hawaii" has been submitted to Dr. Fronk, chairman of the committee. Other committee members are Dr. Edwin Chung-Hoon and Dr. Toru Nishigaya.

Mrs. Patrick Cockett, the only board member from Kauai, will be asked to head a committee in charge of arrangements for the annual convention on that island, May 2-5. The possibility of holding the executive board meeting in Honolulu on May 1 was considered, but because of Lei Day celebrations it was decided to have it on Kauai the opening day of the medical convention.

County Society Reports

Hawaii

The semi-annual meeting of the Hawaii County Medical Society was a dinner meeting at Honokaa Inn on October 4, 1956, with Drs. H. Okada, E. D. Willett, and J. K. Luce as hosts for the evening. Dr. J. Warren White from Honolulu, Dr. Joseph Jensen, and Dr. Chong were present as guests as well as fifteen members of the society.

After dinner, Dr. White, under the auspices of the Trauma Committee of the American College of Surgeons of Honolulu, gave an excellent presentation of various fractures and their treatment. He urged all members to promote the use of safety belts in cars.

In the short business meeting which followed, applications for membership to the Hawaii County Medical Society from Drs. Robert Bell, J. K. Luce, E. Schmidt, and Ruth Oda were accepted unanimously.

Dr. George Tomoguchi gave a report of the meeting of HMSA delegates at Honolulu. This was followed by a discussion by the members on the problems and care of dependents of armed service personnel.

The meeting adjourned at 9:35 p.m.

* * *

A joint dinner meeting of the Hawaii County Medical Society and the Woman's Auxiliary was held at the Yacht Club, Thursday evening, December 6, 1956. Guests present were: Mr. L. D. Rowlands, Vocational Rehabilitation Counsellor for the Big Island, Mrs. Helen Tompkins, president of the Woman's Auxiliary of the Territory, and Dr. Marcelino Avecilla of Pepeekeo. Twenty-two members were present. The Auxiliary arranged a short program by the Gleemen to follow the dinner.

The two groups separated for their respective business meetings. Mr. L. D. Rowlands spoke on "Vocational Rehabilitation Opportunities on the Big Island." Informal discussion took place following the talk.

A letter from Dr. E. Schmidt and Dr. Grant Stemmermann was read requesting County Medical Society support in removing their employment status from Civil Service classification to that of a direct contract with the employer. After a brief discussion, Dr. H. E. Crawford moved that we support that the two positions of pathologist and radiologist of Hilo Memorial Hospital be removed from Civil Service. Dr. N. Steuermann seconded and it was passed unanimously.

Dr. T. Oto gave the high points of the meeting of delegates held recently in Honolulu stating that the House of Delegates voted that the fiscal agent for the dependents' military care plan be HMSA.

Two letters requesting waiver of residence clause for licensure were read: one from Dr. Robert Kaufmann of Pahala, requesting waiver for Dr. E. S. Sarves, who is working at Naalehu; the second from Dr. B. M. Eveleth, requesting waiver for Dr. Frank Tablah, who is associated with him at Kohala. There was also a verbal request for waiver of residence clause by Dr. T. D. Woo for two of his associates at Pepeekeo, Dr. Marcelino Avecilla and Dr. Carl R. Hallik. Dr. Mizuire moved that these three requests be granted and also the requirement of obtaining waiver of residence clause in licensure as ruled by the Board of Medical Examiners be circulated to all members of the society, plantation managers, and employers of physicians. It was seconded by Dr. Yuen and passed unanimously.

The meeting adjourned at 10:10 p.m.

KAY K. OTA, M.D.
Secretary

Honolulu

The regular monthly meeting of the Honolulu County Medical Society was held Tuesday, November 6, 1956, at 7:30 P.M. in the Mabel Smyth Auditorium. Dr. J. M. Felix presided and approximately 80 members and guests were present.

The Scientific Session included the following presentations:

"Medical Aspects of the Menace of Overpopulation," by Dr. K. W. Amano, Tokyo, Japan, guest speaker at the annual convention of Plantation Physicians on Kauai.

"New Diuretics and Their Uses in Patients with Edema," by Dr. David Rytand, Professor of Medicine Stanford University.

New members who were welcomed into the Society were Drs. Clarence Lamar Carter, E. W. Haertig, Mary Elizabeth Johnston, and Ellen Soo Sun Song.

The membership unanimously approved an honorary membership for Dr. Irvine McQuarrie who is presently Educational Director at Kauikeolani Children's Hospital.

Final action was taken on amendments to the Constitution and Bylaws, copies of which had been circulated to the membership.

It was announced that the Fee Adjustment Committee had finally completed its survey on an average fee summary of the Society. Dr. Giles commented briefly on the Fee Survey Questionnaire that was sent out to the entire membership and stated that after completing their tabulations on the returned questionnaires, it was found that the fees for various services compared very closely to those of the California Relative Value Schedule. The committee, therefore, recommended that the Medical Society adopt on a unit basis the California Relative Value Schedule with certain modifications.

Following a discussion, approval of the fee schedule was postponed until the next meeting in order that the membership might have more time to review the Relative Value Schedule.

There being no further business, the meeting adjourned to the lanai for refreshments.

* * *

A special meeting of the membership was held on Thursday, November 29, 1956, at 7:30 P.M. in the Mabel Smyth Auditorium to consider and take action on a request made by the Department of Defense to name another fiscal agent for the Dependents' Medical Care Program. The membership was informed that the Bureau of Medical Economics was not acceptable to the government as the fiscal agent.

After a review of the background, and the experiences of Dr. Boyden's and Mr. Kennedy's trip to

(*Continued on page 334*)

Notes and News

DOCTORS

Elected . . .

. . . to HCMS

Dr. Charles F. Engle was elected to associate membership in the Honolulu County Medical Society. He was graduated from Loyola University in 1909.

. . . to RSHGB

Dr. Walter B. Quisenberry and **Dr. S. D. Allison** were elected to membership in the Royal Society of Health of Great Britain. Dr. Quisenberry was also elected President of the Hawaii Public Health Association.

. . . TAPP's president

Dr. Paul J. Caldwell, physician of the Oahu Sugar Company, was elected new President of the Territorial Association of Plantation Physicians.

Appointed

Dr. Paul Tamura was appointed as Associate Pathologist for the Queen's Hospital. Dr. Tamura is a graduate of Temple University Medical School, Philadelphia. He interned at the Philadelphia General Hospital and took special training in pathology at Temple University. Prior to returning to the islands, he served as Assistant Professor of Pathology at Temple University Medical School.

Distinguished Visiting . . .

. . . internists

Dr. Robert Wilkins, Associate Professor of Medicine at Boston University School of Medicine, addressed the annual meeting of the TAPP in Lihue, and the Honolulu County Medical Society.

Dr. David Rytand, Professor of Medicine at Stanford University School of Medicine, gave a series of addresses in Honolulu and the neighbor islands under the sponsorship of the Hawaii Heart Association and the Honolulu County Medical Society.

. . . surgeons

Dr. Joseph H. Farrow of New York City addressed the Honolulu Surgical Society on "Cancer of the Breast."

Sir Arthur Porrit, Surgeon to the Royal Family of Great Britain, and Lady Porrit stopped in Honolulu en route to the Olympic Games in Melbourne, Australia.

Dr. Francis R. Kenney, Instructor of Surgery, Boston University Medical School, and **Dr. Albert S. Murphy,** Instructor of Surgery at Tufts Medical School, addressed the Hawaii Academy of General Practice on "Pruritus Ani" and "Management of Advanced Malignancy" respectively.

. . . rehabilitationist

Dr. and Mrs. Howard A. Rusk of New York visited Hawaii en route to a lecture tour of Australia. Dr. Rusk is Chairman of the Board of the American-Korean Foundation, Professor and Head of the Department of Rehabilitation and Physical Medicine of the New York University, College of Medicine, and Associate Editor of the New York Times.

. . . EENT men

Dr. Kageyas Wat Amano of Tokyo, Japan, founder of the Japan Planned Parenthood Institute, addressed the TAPP on birth control in Japan. He also spoke before the Honolulu County Medical Society on "Medical Aspects of the Menace of Overpopulation."

Dr. Granville F. Knight of Santa Barbara, California, past President of the American Academy of Nutrition and Fellow of the American College of Allergists, spoke at a public lecture on "Developments in Allergy and Nutrition."

. . . pediatrician

Dr. Manuel Escudero, Director of the Kansas Children's Treatment Center and Chief of the outpatient and admission section of the Menninger Foundation, spoke at the YWCA and at the University of Hawaii on "Residential Treatment Programs of Children."

New Offices . . .

. . . in Kailua

Dr. Robert A. Rose announces the opening of his office at Room 209, Kailua Shopping Center, Kailua, with practice limited to general surgery.

Dr. Hadden Gray announces his association with the Kailua Office of the Medical Group at 539 Kailua Road, in general practice.

Dr. J. F. Woodruff and **Dr. Raymond M. deHay** announce the removal of their offices to the Doctors Building, 407 Uluniu Street, Kailua.

Dr. John R. Sedgwick announces the opening of his new office at 420 Uluniu Street, Kailua.

. . . downtown

Dr. Kenneth E. Ho announces his return to civilian practice at 156 North Kukui Street following twenty-seven months' tour of duty with the U. S. Navy.

. . . in Aina Haina

Dr. R. Varian Sloan announces the opening of his office at Aina Haina Shopping Center for general practice.

. . . uptown

Dr. Robert Y. Katsuki announces the removal of his office to Room 210 Central Medical Building, 1531 South Beretania Street.

Addressed . . .

. . . Aussies

Dr. Ralph B. Cloward spoke before the Neurosurgical Society of Australia in Canberra on the "Treatment of Backache," and "Chemopallidectomy."

. . . Italianists

Dr. Lionello Ferrari, surgical resident at St. Francis Hospital, spoke to The Italian Language Group of the International Institute of Hawaii on "I, Foreign Physician, Not as a Stranger."

. . . polio workers

Dr. John Peyton spoke before Volunteers for the Mothers March of Dimes on certain aspects of infantile paralysis.

. . . televiewers

"What is Your Blood Pressure" was the program presented by the Hawaii Medical Association over KONA-TV on November 14, 1956. Participating in the presentation were **Drs. John I. F. Reppun, Bernard W. D. Fong, Kikuo Kuramoto,** and **Yoshie Takagi.** "My Aching Back" was the title of the December TV program which had **Dr. J. Warren White** for the moderator and **Drs. Thomas S. Bennett, B. Allen Richardson, Sydney T. Fujita** as participants.

. . . prospective parents

Participating in a panel discussion on adoption sponsored by the Child and Family Service, was **Dr. Rodney West.**

. . . The Hawaii Public Health Ass'n

Dr. J. C. Wang, radiologist at the Queen's Hospital, spoke on "New Uses for Radiation in Diagnosis and Treatment." **Dr. Samuel Allison** participated in a panel on "Industrial Health" sponsored by the Association.

New . . .

. . . babies

Dr. and Mrs. Charles S. Judd announced the birth of a daughter, Bonnie Louise, their first child, born on November 18.

Dr. and Mrs. Leslie Vasconcellos are also parents of a daughter, Donna Delores, their fifth child, born on November 21.

. . . husband

Dr. Cecil A. Saunders, formerly of Honolulu, married Mrs. Kenneth Waine Guthrie of Sacramento on November 20 in the Chapel of the Glide Memorial Methodist Church in San Francisco.

Invited to Russia

Dr. Richard You of the medical staff of the United States Olympic team has been invited to the International Congress of Sports Medicine convention at Moscow in 1958. Dr. You said that the invitation was extended by Dr. S. P. Letounow, head of the Russian medical delegation to the Olympic Games at Melbourne. He has been asked to present papers on nutrition and treatment of athletic injuries. He said that he plans to accept the invitation.

Leaving for Alabama

Mr. Gardner Bennett, accompanied by his wife, **Mrs. Edith Bennett,** for many years Managing Editor of the HAWAII MEDICAL JOURNAL, are leaving for Auburn, Alabama, in March 1957 Mr. Bennett will be Professor of Engineering at the Alabama Polytechnic Institute.

NEWS

Resident physician and surgeon is needed on Parker Ranch. Please call 55258 for appointment.

AMA Schedules "Nomenclature" Institutes in 1957

Plans have been announced by the American Medical Association to conduct two—and possibly three—short courses on the use of the *Standard Nomenclature of Diseases and Operations* during 1957. The first Institute will be held March 11-13 in Roanoke, Va., and the second August 5-7 in San Francisco. A third session probably will be scheduled in the fall. All of these three-day meetings are conducted by the AMA as a special service to medical record librarians and others using the Nomenclature in the hospital, doctor's office or medical clinic.

Registration for each session is limited to the first 100 applicants and is not restricted to registered medical record librarians. Anyone contemplating the installation of the system or already using it and employed as a clinic clerk, doctor's secretary or receptionist, nurse or physician may attend. Tuition is free. Applications should be sent to Mrs. Hayden at AMA Headquarters, Chicago.

Seventh International Cancer Congress

The Seventh International Cancer Congress will be held in London, England, July 6-12, 1958 under the Presidency of Sir Stanford Cade. Congress headquarters will be The Royal Festival Hall.

Special emphasis will be placed on Hormones and Cancer, Chemotherapy, Carcinogenesis and Cancer of the Lung.

Proffered papers will only be considered if submitted with an accompanying abstract (not over 200 words) before October 1957 and if dealing with new and unpublished work.

The registration fee for the Congress will be $30 and the latest date for registration without late fee will be *January 1, 1958.*

Registration forms and a preliminary program are available on application to

The Secretary General
Seventh International Cancer Congress
45 Lincoln's Inn Fields
London, W. C. 2, England

(*Continued on page 314*)

Hawaii Medical Association

AMA Delegate's Report of the Interim Session

The Interim Session of the AMA brought about 2,500 doctors—mostly by train or bus, because of persistent fog—to chilly but hospitable Seattle during the middle three days of the last week of November, 1956. There was full attendance, as always, at the House of Delegates, which was convened at 10 o'clock on Tuesday morning by the Speaker, Dr. Vincent Askey of Los Angeles. Your Delegate was honored—sort of—by being appointed one of the five tellers, who were assigned front seats so we could count hands on close votes.

Reports of officers and committees, and reading of about two dozen resolutions, occupied the first day of the session. Meetings of the Reference Committees, hearing discussion of these documents, filled the second day. This is always a most impressive experience, because it demonstrates so well the basically democratic structure of the AMA. Any person—member or not; *doctor* or not!—will be heard courteously and at any reasonable length by these committees, and it is no problem to find and attend their open sessions.

The third day was taken up in hearing, discussing and voting upon the reports of the Reference Committees. Space doesn't permit detailing every one of the actions taken in this way, but the more significant or important ones are briefly detailed in the following list. In these actions, the AMA House of Delegates:

1. Ordered the abbreviated Principles of Ethics held over for further study because sections 6 and 7 failed to cover division of fees, dispensing of drugs and appliances, corporate practice, and the physician-patient relationship.

2. Declared unlawful the medical coverage under V.A. Reg. 6047-D 1 of veterans who are covered by either private or Workmen's Compensation medical insurance, and requested records of such cases to be obtained from each component society.

3. Encouraged the profession "to retain or regain responsibility for the formulation of medical policy of prepaid medical care plans which continue to enjoy medical sponsorship."

4. Instructed the representatives of AMA on the Joint Commission for Accreditation of Hospitals to urge that body to either warn, provisionally accredit or remove accreditation of "community or general hospitals which exclude or arbitrarily restrict hospital privileges of generalists as a class regardless of their individual professional competence *where such policies adversely affect the quality of patient care rendered.* Any action taken should be only after appeal to the Commission by the county medical society concerned."

5. Recommended that hospitals using radium or isotopes have a committee on "radium and artificially produced radioisotopes" including at least a radiologist, surgeon, internist, gynecologist, urologist, and pathologist, plus available consultants, and that use of such substances be limited to physicians adjudged by the Committee (or the nearest Committee) as competent to use them.

6. Ordered joint study of fluoridation of public water supplies carried out during the coming year by the Councils on Pharmacy and Chemistry, and Foods and Nutrition.

7. Modified a resolution to abolish the Interim Session to merely recommend study of separation of Delegates' and Scientific sessions.

8. Ordered service memberships provided for reserve officers on extended active duty.

9. Asked the Trustees to study the advisability of reimbursing Secretaries of Sections for their travelling expenses to and from the Annual Meeting each June.

10. Advanced the delinquency date for suspension of membership (for non-payment of dues) to June 1 in the year 1957. Reinstatement requires clearing of the dues delinquency for the year in which loss of membership occurred, through the constituent medical association.

11. Asked all component societies to inform the AMA of problems or decisions in regard to medical ethics in their jurisdiction, and authorized publication of a compilation of such problems and decisions.

12. Commended the objectives of the American Association of Medical Assistants.

13. Urged physicians to participate in the activities of voluntary health agencies, and medical societies to appoint committees to assist them in achieving their objectives.

14. Approved voluntary reduction, by hospitals, of self-assigned quotas of interns.

15. Ordered participation with the AHA and AIA in a study of hospital design and construction under a USPHS grant.

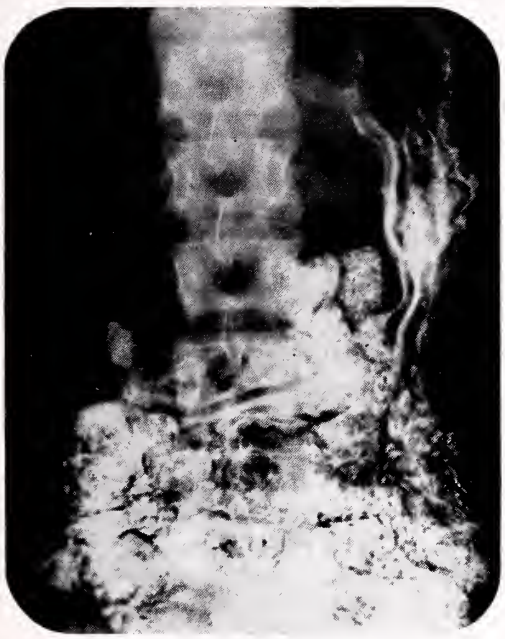
16. Recommended that every American physician join and support the World Medical Association.

Conversations with Dr. Edwin Hamilton, AMA Trustee and chairman of AMA's task force on Medicare, Dr. Frank MacDonald, President-elect of the California State Medical Association; Dr. Robert Novy, long-time (past) President of Michigan Medical Service; Mr. John Castelucci, Executive Director of the Blue Shield Medical Care Plans; and two or three other men, disclosed a strong and virtually unanimous opinion among them that the fiscal agent for Medicare should be fully controlled by the medical profession—and, indeed, that the claims-disbursing agency for *any* service type of doctor-sponsored prepayment plan should be fully controlled (i.e., with at least a

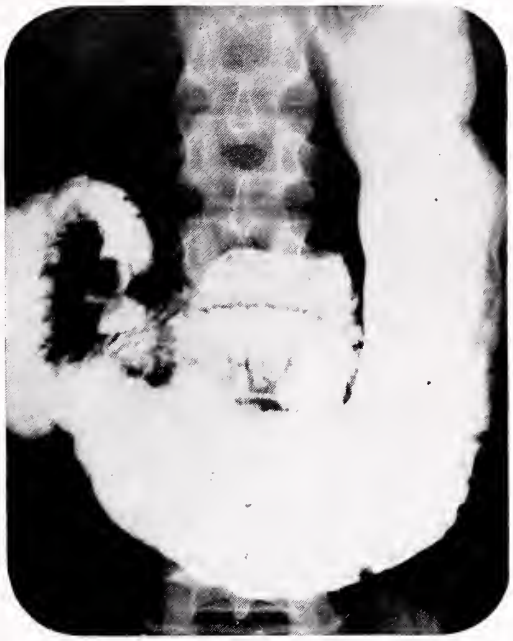
(*Continued on page 322*)

Reduced Hypermotility with Pro-Banthine®

Improves Visualization



*Posterior-anterior film: definite hyperperistalsis with poor duodenal visualization.**



Posterior-anterior film after 15 mg. of Pro-Banthine intramuscularly: chronic duodenal ulceration clearly disclosed.

The same anticholinergic action which has made Pro-Banthine (brand of propantheline bromide) the outstanding therapeutic agent in peptic ulcer has also proved valuable in diagnosis.

By controlling the hypermotility, Pro-Banthine may permit delineation of a lesion otherwise not clearly visualized.

The technic is simple: If the first set of films shows hypermotility but no filling defect is demonstrable, reexamination is done a few minutes after intramuscular injection of 15 mg. or a half hour after oral administration of 30 mg. of Pro-Banthine.

This procedure has the additional advantage of demonstrating the patient's response to a given dosage of the drug.

G. D. Searle & Co., Chicago 80, Illinois, Research in the Service of Medicine.

*Roentgenograms courtesy of I. Richard Schwartz, M.D., Kings County Gastrointestinal Clinic, Brooklyn, N.Y.

SEARLE

INTER-ISLAND NURSES' BULLETIN

Official Publication of the Nurses' Association, Territory of Hawaii

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President's Message

Now that the Christmas season with all of its joy and gaiety is over, we are all ready to begin a New Year. This seems a good time for each of us to make some new resolutions and to remember, perhaps a little shamefacedly, those we made with such sincerity a short twelve months ago.



LYNNE WIGEN, *President*

It is expedient that we also remember some resolutions we made collectively while assembled in our annual convention in September. We committed ourselves, as delegates representing all of our members, to support certain groups in their sincere attempts to promote better patient care. I'm certain you have all heard of the action taken by the House of Delegates; however, perhaps it is well to restate, briefly, two of these resolutions. The Nurses' Association, Territory of Hawaii, pledged its full support to the Territorial Hospital in its request for additional personnel and recommended that evidence of this support be given the widest possible circulation through all media which we may have available.

In addition, we adopted the resolution of the Public Health Nursing Section recommending and urging that the Territorial Legislature be again informed of the need for additional personnel to accomplish adequate public health nursing services on all Islands. We went on record as urging the appropriation of additional positions and funds needed to expand these services as recommended.

To accomplish enactment of legislation to insure the success of these programs will take real effort on behalf of an interested informed membership. This is not the time to assume it is the other person's job . . . it's yours and mine! Let us not be an organization which "endorses," gives lip service so to speak, but fails to come through when our support is needed.

The New Year presents a fine vantage point from which to review, as well as to look ahead. What did we set out to do a year ago that remains undone? If it were a sound, worthwhile project, let us use our backward glance to guide our forward action. Admitting that we didn't accomplish everything we set out to do, that some projects fell short of completion, is no reason for discouragement. But let's get on with it.

Sound programs mean active committees, which in turn need interested members. This brings us again right back to you, the individual nurse member, the only foundation upon which N.A.T.H. can build a vigorous, active organization.

May health, happiness, and abundant success be yours throughout this coming year.

LYNNE WIGEN, R.N.

Editorials

SUPPORT NURSING LEGISLATION

At our last convention delegates unanimously pledged to support two resolutions of the Legislative Committee. These were additional nursing personnel for the Territorial Hospital and additional public health nurses for the Department of Health.

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EDITOR



ROSIE CHANG, R.N., B.S., M.Litt.
Director of Nursing
Territorial Hospital

Clinical and Technical
Nursing care studies, new medications,, nursing techniques, nursing arts, and science



DORIS GREGORY, R.N., B.S., M.Ed.
Educational Director, Queen's Hospital

General Interest
Scholarships, educational programs, conventions, opportunities in nursing, world affairs, etc.



ANNE CAMARA, R.N., B.S.
Educational Director, Leahi Hospital

District and Section News
Activities of districts and sections



NORA SHIROMA, R.N., B.S.
Public Health Nurse, Department of Health

ASSOCIATE EDITORS

Nursing Education and Nursing Service
Inservice programs, refresher courses, Book Reviews, trends in nursing, current practices



MILDRED KIM, R.N., B.S.
Assistant Director of Nursing, Queen's Hospital

Upon the recommendation of Judith Whitaker, ANA Deputy Executive Secretary, and the implementation of this change by the NATH Board of Directors, the Nursing Information Committee will now include all publicity (radio, press, television), INTER-ISLAND NURSES' BULLETIN and the Newsletter. This was done to coordinate and disseminate all news releases and nursing information from one committee.

The NATH Board of Directors appoints the Chairman of the Nursing Information Committee the Editor of the BULLETIN.

Under the present organization, the Editor of the INTER-ISLAND NURSES' BULLETIN will be assisted by four Associate Editors who will be responsible for specific divisions.

Each issue will contain items of interest from each division. It is tentatively planned that each issue will feature a theme of interest to all nurses.

The theme for this month is "Legislation." In April the theme will be "Economic Security."

The staff of the INTER-ISLAND NURSES' BULLETIN invites you to comment and offer suggestions that will improve the Bulletin.

EDITORIALS

(*Continued from page 300*)

Additional personnel is needed at the Territorial Hospital to provide adequate and safe nursing care, eliminate 16 hour a day duty, enable nursing personnel to take vacations and holidays, and provide adequate ward coverage during sick leave.

Additional public health nurses will provide adequate public health nursing services on all the islands.

Nurses Association, Territory of Hawaii, of which you are an integral part, includes in the list of functions the promotion of standards in nursing and legislation concerning health and welfare programs.

Therefore, it is time for you to come to the aid of your association to do your part in informing your legislators the need of appropriating necessary funds to provide adequate staffing for the Territorial Hospital and additional public health nurses for the Department of Health.

Clinical and Technical

THE USE OF ATARAXIC DRUGS IN MENTAL ILLNESS

ROBERT S. SPENCER, M.D.*

A new group of tranquilizing drugs has recently been discovered and is now in extensive use. These drugs are called "ataraxics," a term which comes from the Greek word *ataraxia* which means freedom from disturbance or passion. There are many such compounds and new ones are being marketed almost daily.

Those which have had extensive clinical use can be roughly categorized into four groups: (1) derivatives of Rauwolfia serpentina or Indian Snake root, (2) the phenothiazine compounds, (3) compounds related to mephanesin, and (4) miscellaneous compounds.

Rauwolfia serpentina has been used for centuries in India for various ailments including mental illness. Recently, in this country the whole root has been found to be effective in treating hypertension. In testing various fractions of the whole root, one fraction, reserpine, showed little effect on blood pressure but demonstrated a profound tranquilizing effect. It is marketed by several companies under various trade names: Serpasil, Reserpoid, Sandril, Raused, Eskaserp, and others.

* Clinical Director, Territorial Hospital, Kaneohe, Oahu.

The phenothiazines were developed as antihistamines in France. One of these compounds, chlorpromazine, with the trade name of Thorazine, has been used extensively in almost all specialties of medicine, but primarily in psychiatric patients. Another phenothiazine is Promazine, which is marketed as Sparine.

Meprobamate, a mephanesin derivative, is made and sold under such names as Miltown and Equanil. This drug seems to have limited use in a mental hospital but is used in treating mild anxiety symptoms.

Some of the other drugs in clinical use such as azacyclonal, with the trade names of Frenquel, and hydroxyzine hydrochloride, with the trade name of Atarax, have not yet had sufficiently extensive clinical trial to be compared with chlorpromazine and reserpine.

Very little is known of the sites or mechanisms of action of chlorpromazine and reserpine. Following administration, they are found in all tissues of the body, but in greater concentration in the central nervous system, and more particularly, in the mid-brain and hypothalamic areas which are the presumed sites of action. The response to treatment with these drugs in the mentally ill is as yet somewhat unpredictable and indications are not well defined. However, it appears they are most effective in the individual with increased physical and mental activity. Retarded patients do not respond as well and caution must be used in depressed individuals as the depression may be increased.

The side effects of these drugs are numerous. Minor reactions such as hypotension, drowsiness, and frightening dreams are found with both while nasal stuffiness and diarrhea occur with reserpine. Skin eruptions and constipation may result from the use of chlorpromazine. More serious side effects such as Parkinsonism and other neurological disturbances occur fairly frequently with both, but can often be controlled by the usual anti-parkinsonism drugs such as Artane and Cogentin. Occasionally, cases of edema occur with reserpine and an obstructive type of jaundice occurs with chlorpromazine. In addition, rare cases of agranulocytosis have been reported with deaths.

The ataraxic drugs have given the psychiatrist an additional tool with which to treat mental illness. However, these substances are effective only in some patients. They are potent chemo-therapeutic agents with possibly serious consequences and, therefore, must be used with caution. Much research still remains to be done before their indications and contraindications can be well delineated.

NURSING CARE PROBLEMS ASSOCIATED WITH THE USE OF ATARAXIC DRUGS

ETHA B. COULTER, R.N., B.S.*

There has always been a feeling of deep concern on the part of the medical and nursing staff for the chronically ill mental patient who seems destined to spend the remainder of his life in the hospital. All the known treatments have been tried on these patients with little or no response. In the past two years, many articles have been written about the new "Ataraxic" drugs, or "tranquilizing" drugs and the renewed hope these drugs have given for this group of patients.

There are several hundred patients in this classification at the Territorial Hospital. The women's disturbed ward of 60 patients has over 90% in this category. The ages range from 12 to 75, and length of illness in hospital from 3 to 40 years. The psychiatrist in charge of the ward decided to use Thorazine in treating certain of these patients. The patients selected were the 15 most disturbed and combative.

The dosage used for the majority of these patients was 100 mg three times a day, with an increase of 100 mg per dose every 3 days until a total daily dosage of 4000 mg was reached. With two of the patients, both over 60 years old, the increase was made weekly rather than every three days.

The nursing problems started the day following the start of treatment and grew daily. One of the first and continuing problems was that of getting the patient to take the medication. Two of the patients required intramuscular administration of the medication until they became cooperative enough to take it by mouth. As the dosage was increased, the problem increased. The largest Thorazine tablet is 200 mg and it became increasingly difficult to get the patient to swallow seven of these three times a day. As the dosage was increased, some of the patients developed a severe stomatitis and semi-paralysis of the throat muscles which made it impossible for them to swallow the tablets. For these patients, we pulverized the tablets and gave the powder with copious amounts of water. Thorazine tablets are sugar coated and pleasant, but very bitter without this coating. This naturally adds to the patients' resistance.

One of the side effects of Thorazine is the development of Parkinson's symptoms—unsteady gait, tremors of the lips and fingers, and slurring of speech. Artane 2 mg, b.i.d., or Cogentin 2 mg, b.i.d., was given to help counteract these symptoms. Most of the patients started to develop these symptoms on the second day. This required constant observation and help to prevent falling and injuries. Also, because of the tremors, it was necessary to spoon-feed some of the patients.

Two patients developed a dermatitis which was treated with Teldrin Spansules b.i.d. In five of the patients severe drooling was controlled by atropine sulphate gr. 1/150 b.i.d. Three patients manifested severe edema of the extremities and face. Bi-weekly injections of 2 cc of Thiomerin and daily administration of Diamox 250 mg helped to relieve these symptoms.

Because Thorazine tends to be constipating, all bowel movements had to be checked. It was necessary to give milk of magnesia three times a week. Several of the patients also required enemas.

Temperature, pulse, and blood pressure were checked daily. If the systolic pressure had gone below 100 and the diastolic pressure below 60, the medication would have been discontinued immediately. Also, as thorazine may destroy the white blood cells with resulting agranulocytosis, a white blood count was done weekly. Two blood counts fell below 3000 and the medication was immediately stopped. The counts returned to normal in two weeks.

Marked depression and sluggishness were noted in six patients. They were given Ritalin 10 mg three times a day, and daily dexamyl spansule 15 mg. Four of the patients became increasingly combative and had to be kept in almost continuous seclusion for about two weeks.

Three patients developed a severe pseudo-membranous stomatitis and partial paralysis of the throat muscles. The stomatitis was treated with frequent hydrogen peroxide mouth wash. Serpasil 1 mg three times a day was given to relax the throat muscles. It was necessary to give pureed and liquid diet to these patients.

Thorazine lowers the convulsive threshold and six of the patients started having frequent severe grand mal convulsions. They became very cyanotic and often failed to breathe following the seizures. The way in which artificial respiration was administered depended upon the position of the patient. Often it was given with the patient in a sitting position.

The course of treatment extended from August 13 to October 1. During this time the staff on the ward consisted of one registered nurse and one psychiatric aide from 7 to 3 and one psychiatric aide from 3 to 11 and 11 to 7.

Three of the patients showed no effects of the drug and remained unchanged. Four showed great improvement and have been able to go to open wards. The remaining patients are less combative, but show no other change. It was a very interesting and challenging treatment as far as the staff is concerned and we are willing and anxious to

* Psychiatric Nurse, Territorial Hospital, Kaneohe, Oahu.

try any other new treatment that may benefit our patients.

PREDNISONE AND PREDNISOLONE

MARGARET THOMAS

Prednisone and prednisolone are new and highly potent cortisone-like steroids having powerful anti-inflammatory action and diversified hormonal and metabolic effects. Like cortisone, they are potent therapeutic agents, influencing the biochemical behavior of most, if not all, tissues of the body. In contrast to cortisone, however, markedly lower doses are required to obtain a therapeutic effect. Only limited clinical studies with them have been conducted to date. Patients receiving these drugs must be kept under close observation and the dosages recommended not exceeded. Physicians should endeavor to keep in close touch with the current medical literature as additional information accumulates concerning studies on the drugs.

All of the precautions and contraindications for cortisone apply at this time to these drugs. However, because considerably less sodium retention and potassium excretion occur with the recommended therapeutic dosages, the usual signs of overdosage such as increase in weight, moonface, etc., cannot be relied upon as signs of overdosage, and for this reason additional precautions should be taken.

The suggested suppressive dosage for severe rheumatoid arthritis is 30 mg per day. In less severe cases, 20 mg per day will generally suffice. This suppressive dosage is continued until a satisfactory clinical response is obtained, a period usually of three to seven days. Dosages above 30 mg per day for initial therapy are not recommended. After a favorable response is noted, the proper maintenance dosage should be determined by decreasing the suppressive dosage 2½ mg per day every two or three days. By this method, the minimum daily maintenance dosage can be determined. The maintenance dosage should range between 5 and 20 mg per day and should not be exceeded. In all cases, both for suppressive and maintenance therapy, the total daily dosage should be divided into four parts and administered after meals and before retiring.

Suppressive dosage for intractable bronchial asthma ranges from 20 to 30 mg daily, depending upon the severity of the disease, and need be continued usually for not more than three days, maintenance dosage, when required, ranges from 5 to 20 mg daily in divided doses.

The side effects so far reported with prednisone in therapeutic dosages have been mild. Insomnia has occasionlly occurred during the first day or two of therapy. Slight gastric distress has sometimes been noted. Glycosuria and hyperglycemia may occur, therefore, diabetic patients receiving prednisone should have careful supervision. There is evidence that the incidence of peptic ulcer has increased markedly in patients on long-term therapy. Prednisone should not be used in patients with active tuberculosis. It may be administered to patients with other acute or chronic bacterial infections provided the infections are controlled with appropriate anti-biotic or chemotherapeutic agents. It should be kept in mind that prednisone through its anti-inflammatory action will hide the signs of infection such as elevation of temperature.

Unless studies now in progress should prove otherwise, the possible action of prednisone in delaying wound healing should be kept in mind.

Prednisone is supplied only in tablet form. It appears on the market under the following trade names: Deltasone by Upjohn in 5 mg and 2.5 mg tablets; Deltra by Sharpe and Dohme in 5 mg, 2.5 mg, and 1 mg tablets; Meticorten by Schering in 5 mg, 2.5 mg, and 1 mg tablets.

Tablets of prednisolone include Delta-Cortef by Upjohn in 5 mg, and 1 mg; Meticortelone by Schering 5 mg, 2.5 mg, and 1 mg; Sterane by Pfizer 5 mg, and 1 mg; and Hydeltra by Sharpe and Dohme 5 mg, 2.5 mg, and 1 mg.

Schering supplies a sterile ophthalmic suspension containing prednisolone under the name Metimyd, also a cream, Meti-Derm. Upjohn is now supplying an ointment under the name Neo-Delta-Cortef containing the antibiotic, Neomycin, along with prednisolone.

Pfizer has just recently produced a combination tablet containing Sterane 5 mg and Atarax 10 mg, called Ataraxoid. It is valuable in the treatment of a variety of collagen and allergic disorders complicated apprehension, anxiety, and tension. Such disorders include rheumatoid arthritis and the other collagen diseases, allergic states, allergic and other inflammatory diseases of the skin, allergic and other inflammatory diseases of the eyes. In these conditions emotional stress is present as a complicating, or even a causative, factor. In addition to the suppressive and anti-inflammatory action of prednisolone, Ataraxoid tablets at the same time advantageously provided the tranquilizing and calming action of atarax, with alleviation of anxiety, tension, and agitation and lessening of psychomotor activity. Ataraxoid is not recommended for long-term use but it may be used for better control initially and then be replaced by prednisolone. Its main drawback is that not all patients need the same ratio of Atarax to prednisolone offered by the tablets.

Nursing Education and Nursing Service

EDUCATIONAL PROGRAMS FOR NURSES

LEONA RUBBELKE, R.N.*

Educational programs for nurses are offered at many Oahu hospitals to improve nursing care of patients. One example of such a program is the inservice education at Tripler General Hospital under Capt. Emma Heske, who is in charge of program planning and management. A symposium on Pediatric Nursing was recently held and emphasis was on the Emotional and Physical Growth and Development, and the influence of these factors on the sick child. Forty-five nurses and auxiliary personnel participated in the discussion which covered such areas as:

1. Physical growth patterns and their influence on children's behavior.
2. Emotional aspects of illness.
3. Normal reactions to hospitalization.
4. Ways of helping families and children to adjust to a hospital experience.
5. Safety factors in infant and child care.
6. Specific problems of nursing care in children such as control of extremes in temperatures, and cross infection on a communicable disease unit.

A film entitled *A Two Year Old Goes To The Hospital* was shown to provoke discussion on "mother deprivation and what this means to a young child." Resource staff who contributed to the success of the program included Nurse Consultants Miss Yukie Takagi, Division of Mental Hygiene, and Miss Leona Rubbelke of the Bureau of Maternal and Child Health.

Another example of educational programs for nurses is the Workshop on Current Trends in Maternity and Child Health. This was held in October and repeated in December, under the sponsorship of the Consultants and auxiliary professional staff of the Board of Health. Thirty-two nurses participated in each of the two workshops and represented various hospitals, doctors' offices, American Red Cross, Navy Relief, and Public Health Nursing. The content of the workshop is listed below:

Session I

Modern Trends in Maternity in Hawaii
The Changing Role of the Nurse
The Effect of Posture on Pregnancy and Health
Prevention or Alleviation of Discomforts of Pregnancy
Practice Session—Prenatal Exercises and Abdominal Breathing
Movie: *Biography of the Unborn*

Session II

Preparation of Expectant Parents for Labor and Delivery
The Changing Role of the Father
The Nurse Helps the Mother Meet Emotional Crises During Labor and Delivery
Practice Session—Relaxation
Comfortable Positions for Labor and Delivery—Teaching Panting, Pushing, Proper Breathing
Movie: *Childbirth is a Family Affair*

Session III

Development of Health Maternal-Child Relationships
"Rooming In"
Movie: *A Two Year Old Goes to the Hospital*
Practice Session—Post-partum Exercises and Review
Modern Trends in Nutrition

Session IV

The Newborn Baby—Current Trends in Nursing Care
Growth and Development Patterns Significant in Parent Education
Practice Session
Movie: *Sibling Relations and Personality*
Evaluation

THE INDUSTRIAL NURSE

Those of us who are actively engaged in the fight to control industrial accidents are aware of the important role the industrial nurse is playing in Hawaii's industry.

Many progressive companies such as The Hawaiian Electric Co., Hawaiian Pineapple Co., Hawaiian Tuna Packers, Hawaiian Telephone Co., Dairymen's Association and others have had an industrial nurse on the job and the safety records of these companies attest to the value of this service to their employees.

Unfortunately, many companies have overlooked the real value of the industrial nurse and sooner or later will be due for a rude awakening.

Hawaii's new Workmen's Compensation benefits make it almost a "must" to have a competent industrial nurse on the job in the larger industries.

The company nurse of today is more than a dispenser of pills and adhesive tape. While her main duty is helping protect the health of employees, her influence on the morale of an organization extends far beyond the physical limitations of treating minor injuries or arranging proper medical care for the ill.

Working closely with those charged with safety, the industrial nurse is the key figure in an integrated program of Health and Safety Service. Years of technical training together with experience in dealing with health problems of industrial workers are the foundations for success in this

* Maternal Nursing Consultant, Department of Health.

specialized branch of an honored profession. The industrial nurse, whose understanding and sincere interest in people is coupled with a personality that creates confidence in workers, is often overlooked as one of the important links in a successful accident prevention program.

As industry grows in Hawaii, so will the need for the industrial nurse.

General Interest

TERRITORIAL HOSPITAL BUDGET PROGRAM FOR 1957-1959

ROBERT KIMMICH, M.D.*

The Territorial Hospital at Kaneohe has been understaffed and overcrowded since 1870. It has always been difficult for the Territorial Government to face directly the fact that mental breakdowns occur with great frequency and that adequate care for these ailing citizens is an obligation.

The Territory cannot afford to continue making appropriations which only allow for a substandard program. The greatest economy is the long range approach in which treatment, early and adequate, returns people to the community instead of leaving them without proper treatment to be institutionalized indefinitely. The cost of maintaining a patient in the hospital for years is much greater than the cost of early intensive treatment resulting in improvement and discharge.

In an attempt to save money, the Legislature has only allowed the Hospital 55 per cent of the staff it needs. This shortage is most easily observed in the Nursing Service where it is necessary for two or three psychiatric aids to work straight 16 hour shifts daily since there are not even enough people to allow for sick leaves and days off.

Continuance of this situation will result in loss of our provisional accreditation by the Joint Commission on Accreditation of Hospitals. This in turn will cause loss of professional staff and the impossibility of recruiting quality staff members. The present budget allows for treatment of only about 40 per cent of our patients; with loss of accreditation, it will be a smaller figure.

The cost of a good program which essentially meets national standards amounts to $6.08 per patient a day for 1957-1959 (1955-1957 Budget: $3.82). When this figure is compared with patient-day costs in general hospitals, it becomes meaningful. It is a remarkably low cost for good psychiatric hospital care; yet it can be done. The total operating budget for the two years would amount to $5,400,000. Sixty-five per cent of this is for personnel.

Such a program will allow for appropriate treatment of all the patients. The inpatient population will be cut down by at least 100 patients in the two years. Hospital stay of first admissions will be shortened by about one-third. Staff efficiency will improve and nursing personnel will have a 40 hour week.

The only economical action is to give the necessary program to get patients out of the hospital as soon as possible in an improved mental condition so that they may reinstitute a life in the community.

* Medical Director, Territorial Hospital.

WHY MORE PUBLIC HEALTH NURSES?

ALISON MACBRIDE, R.N.*

The Health Department is requesting fourteen public health nurses, one supervisor and a clerk. NATH, one of the principal organizations interested in community health services, will support this request in the next session of the Territorial Legislature. Here are some reasons why Hawaii needs to increase its public health nursing staff:

Public health nursing is an essential community service, which in Hawaii is provided through only one agency—the Territorial Health Department. The public health nurse's services are available to any individual or family without charge and the service may be requested by any source—private physician, hospital nurse, school teacher, a member of the family, a social agency, a church worker.

The services rendered by public health nurses are primarily directed toward the prevention of disease and the promotion of health. The nurse uses an educational approach and helps people to help themselves to better health. Here are some illustrations of what these services are and how they are given by public health nurses:

The nurse visits the public and parochial schools in her district throughout the school year. She is the school's nurse. A classroom teacher has observed a seven year old boy with symptoms suggestive of rheumatic fever. The nurse in a home call reviews the child's history and persuades the mother to take the child to the family doctor who finds that he has rheumatic fever. The doctor prescribes a prophylactic regimen to prevent the development of rheumatic heart disease, and the public health nurse keeps the youngster under her general supervision throughout his school period.

A father has been discharged from a hospital with his diabetes regulated. He requests the nurse to visit to check his insulin technique. In the course of the visit the nurse (using the simple Tes-Tape method) tests the urine of members of the family and finds that the 12 year old daughter has sugar. Subsequently the daughter is seen by the hospital clinic and found to have diabetes which can be regulated by diet at this stage.

* Chief, Bureau of Public Health Nursing, Territory of Hawaii.

In the child health conference (clinic for well infants and preschoolers) a young mother is helped to understand how her baby grows and the care he needs at various stages of development. This guidance prevents the development of strain in parent-child relationships at critical periods such as weaning, toileting, et al.

The nurse teaches a class of expectant mothers, who because they know what to expect and how to cooperate, have a happier childbearing experience.

A paraplegic aunt leaves the hospital and the nurse visits to give the nursing care and to teach the family this care and rehabilitation measures.

The PTA Program Chairman solicits the nurse's help to arrange a program and film on early discovery of cancer.

The nurse is visiting a camp and a young man shows her his fingers which gave him no sensory warning when he picked up a hot rock. The young man spent a year at Hale Mohalu and has now returned to his home and job.

We have nurses for thirteen districts on Hawaii, eight on Maui, seven on Kauai, one on Lanai, one on Molokai and forty on Oahu. This is the same number of nurses the Health Department had in 1950 and in the last six years there have been changes both in the health services program on all islands and on Oahu plus a tremendous increase in population. Both these factors have seriously taxed the public health nursing service. The ratio of nurse to population on Oahu has almost reached 1 to 10,000 as compared with the recommended standard of 1 nurse to 5,000 population.

It should be remembered that public health nurses are required to put into action almost every phase of the public health program which has to do with personal health. The changes in health services in the past six years which are very dependent and demanding on nursing have been several:

Tuberculosis work has increased (even though the mortality is reduced) due to the shorter periods of hospitalization and the close supervision required for patients discharged on drug therapy, and there have been several refinements in tuberculosis case-finding programs which require increased nursing service; special services have been made available for children with handicapping conditions such as hearing loss, mental retardation, and other conditions. Maternal and child health work has suffered. The aging are largely neglected in our community by health and social agencies. In their district "rounds," nurses keep "stumbling" across older folks who need services but are unable to give the needed services. Family problems are increasing in complexity and this fact requires considerable time in conference with other professional workers to plan how help is to be given.

Health department nurses are the school nurses for public and parochial schools of the Territory. The school health service helps children make the best use of their educational program. A conservative estimate is that 10 per cent of school children have some health or behavior problem, which conceivably can interfere with school work. The nurse helps to identify these children and to bring about a satisfactory adjustment of the health problem; she assists in preventing the spread of disease, and is a health consultant to the staff and to parents. With the present inadequate staff the nurse is an infrequent school visitor. This means failure to fully enlist parent's cooperation in solving known health problems and many children with health deviations go unrecognized since nurse-teacher contacts are very limited in number throughout the school year. Oahu's school population this year is 21,000 greater than in 1951.

The above reasons are basic to the Department's request for fourteen more public health nurses, one supervising nurse, and one clerk. Oahu needs four nurses, the supervisor, and clerk just to keep up with the present health service requirements of its growing population. The other ten nurses are needed to give all islands a better school nursing service. Two of these nurses would be assigned to the Big Island, one to Kauai, one to Maui and six to Oahu. This assignment, based on actual school enrollment, would provide each classroom with twelve hours of the nurse's time in the course of a school year.

The people of the Territory through their legislators decide biennially what service and how much service they want from their Territorial government. No government service can develop without legislative sanction. No legislator can vote intelligently unless he knows what people want. Because you are nurses, you are the logical people to tell legislators what nursing services the people want and NEED.

NURSE LICENSING PROGRAM THREATENED

ALISON MACBRIDE, R.N.*

The government workers' pay raise bill passed by the special session of the Legislature authorized the use of $13,290 from the Board for Licensing fund "reserve."

The formula used by the Territorial auditor to estimate this reserve did not take into account the fact that almost half the Board's revenue is received by September 1. In actual fact, the estimated reserve which could be used without interrupting the licensing program is $5,118.

The Board's funds are being withdrawn by the auditor's office at the rate of $1,300 a month. The

* Chairman, Board for the Licensing of Nurses, Territory of Hawaii.

Board has taken steps to curtail expenditures including eliminating a half-time clerk, eliminating January professional nurse examinations and purchase of much needed office equipment, postponement of a long overdue survey of the Practical Nurse School, and revision of obsolete record forms. Besides cutting all possible expenditures, the Board will not be able to pay staff salaries, rent and other operating costs after March 1, 1957. This means that the licensing program will be discontinued on March 1. Although renewals are again done on July 1, there will not be adequate revenue to pay operating expenses before September 1.

Special legislation in the coming session is essential if the Board for Licensing is to continue its operations through this fiscal year and until adequate revenue is received.

INTER-ORGANIZATIONAL COMMITTEE FOR THE TERRITORIAL HOSPITAL

MRS. HELEN HULL, *Chairman*

Eleven territory-wide organizations have joined forces to bring action supporting the Territorial Hospital at Kaneohe.

The Inter-Organizational Committee for the Territorial Hospital is an independent group composed of representatives of the following organizations:

We, the Women of Hawaii; Nurses' Association of the Territory of Hawaii; Chamber of Commerce of Honolulu; Mental Health Association; Territorial Hospital Auxiliary; Hawaii Federation of Women's Clubs; Oahu Health Council; Junior Chamber of Commerce of Honolulu; Hawaii Medical Association; Honolulu County Medical Society; Hospital Association of Hawaii.

Members of the new inter-organizational group have dedicated themselves to achieve:

1. Territory-wide recognition of the urgent need for improvement of conditions at the Territorial Hospital.
2. Support for maintenance of services at the hospital which would allow it to be accredited nationally by the U. S. Joint Commission on accreditation of Hospitals in order to maintain a competent staff.
3. Adequate legislative funds through full support by the governor and the members of the legislature.

Final organizational meeting of the inter-organizational group was held at the Chamber of Commerce board room a few days ago.

First meeting to plan the committee was held October 1 after the Mental Health Association and We, the Women had produced the new film *One out of Ten.*

First meeting with the governor by the early group was October 10 when he was asked to support a larger share of budgeted funds for the Kaneohe hospital.

Representatives on the committee are chairman, Mrs. William Janney Hull, We, the Women of Hawaii; Olive C. Pridgen, Nurses' Association; Elroy Chun, Mental Health Association; Mrs. R. C. Allen, Territorial Hospital Auxiliary; Margaret P. Lawrence, Hawaii Federation of Women's Clubs; Mrs. George Kellerman, We, the Women; Kenji Goto, Oahu Health Council; Mrs. Rosie Chang, Nurses' Association; Mrs. Edward Holroyde, Territorial Hospital Auxiliary; R. M. Kennedy, Honolulu County Medical Society; Sister Maureen, Hospital Association; Lee McCaslin, Hawaii Medical Association; Rita Widasky, Territorial Hospital Auxiliary; Lorrin F. Thurston, Junior Chamber of Commerce; Addison Love, chairman, Territorial Hospital subcommittee of the Chamber of Commerce Public Health Committee; and Allan Bush, chairman of the Public Health Committee, Chamber of Commerce.

PROGRESS OF PRACTICAL NURSING IN HAWAII

ANNE CAMARA, R.N.*

I consider the invitation to speak to you this morning an honor and a privilege, and I am most grateful and appreciative of this opportunity. I cannot actually say in words how I truthfully feel within my heart to be included in your program of activities.

As I look over this beautiful setting—the Robert L. Stevenson Room of the Princess Kaiulani Hotel—a vacationer's paradise, I cannot help but marvel at the great strides you have made in relatively a few years.

There are moments in our lives when we need to take stock of our many objectives in life. One of these is the "spirit of nursing" with which every one of us is deeply concerned. You and I sincerely recognize that whether walking alone or with others, we have in common two primary goals in our vocational dedication. One is the best patient care possible and the other is that we retain and cherish all the true values of nursing that make it good.

In these times of so much medical and scientific expansion, we are constantly confronted with a greater variety and volume of nursing needs. Today, we sense the growing demands on nursing for greater skills, versatility, and responsibility, which are a tribute and a challenge to all of us.

The hospital and other health agencies think of the practical nurse as an integral part of the health team. This has been a most significant element in the last few years. As a reminder, you realize that the care of a patient requires a con-

* Text of speech made by Mrs. Camara at the 1956 Annual Meeting of the Practical Nurses' Association, Territory of Hawaii.

sideration of his needs as a whole individual—his spiritual, emotional, physical, mental, social, and environmental well-being. Such care takes every member of the health team of which you are a part. The real worth of the practical nurse is determined by the same standards as those used to evaluate the professional nurse—knowledge and the ability to apply it, experience and judgment, and the realization of the need to grow in competence and understanding.

I would like to take this opportunity to review the many advances you have made in the last few years. You have come a long way in a very brief time.

On the national level for instance, there are two very important organizations, the National Association for Practical Nurse Education, organized in 1941, and the National Federation of Licensed Practical Nurses, which was established only seven years ago. The two organizations have grown by leaps and bounds in every sense of democratic progress—membership, prestige, dignity and international recognition. You must be proud of them. Since their beginnings, both associations have been vitally concerned with the organization of a Practical Nurses' Association on the state and territorial level; with legislation affecting the practical nurses and with continuing education for practical nurses. The fellowship, sincerity of purpose, and ability of its officers and members should result in added recognition for the practical nurses and the humanitarian services which they render. Another material expansion that we have seen in recent years is the dramatic growth of state licensing laws for practical nurses. I remember so well, just a few years back, when only two states, plus Hawaii, had licensure. Now, 48 states and territories have state laws for licensing.

Another issue is the growth of practical nurse schools throughout the country which has been a fascinating development. Less than ten years ago, we had less than 20 approved schools. Today, there are over 400 approved schools for practical nurse traineeship.

At this moment, therefore, I am deeply touched by your enthusiasm and determination to elevate the standards of your vocation and organization on the territorial level. The true spirit of aloha is demonstrated in each and every one of you. I see the infectious laughter of fellowship and the warm friendliness of this group, meeting together with the same interests and ideals for the promotion of better health for our citizens.

Do you realize that right now you are in the public's eye? You are exemplifying your role as a vital part of this community. Growing up as an organization paves the way for added dignity, prestige and recognition to your status among your fellowmen.

The growth in all aspects of practical nursing in Hawaii within a short time has been tremendous. One of the outstanding trends is the universal acceptance of the licensed practical nurse on the health team. For a while, there was some resistance on the part of some of our professional workers, but within a short time they have fully realized the invaluable service and contribution of the practical nurse in the hospital.

Secondly, we have witnessed the wonderful spirit of cooperation of your group with other members in health work and deeply admire your ability to recognize your distinct duties in a work environment.

In a relatively short time, we have seen local hospitals allocating additional nursing duties to the practical nurses formerly executed only by the professional nurses. You have proved your worth by this advancement.

Here is another point of interest. The education of the public as demonstrated in schools, various community organizations, and others through your efforts, has made recruitment for practical nurse training an attractive and enlightening vocational program. More girls are applying for our local traineeships than ever before.

Only a few years back, we witnessed your active participation in national conventions—a forward step in vocational and professional advancement for the practical nurses in Hawaii. Your sincere interest and hard work are worthy of this achievement.

As a result of your affiliation, your participation in the San Francisco conference last year led to the post-convention visit of your national officers to Hawaii. We will no doubt see more of this in the years to come. I have been informed that one of your own nurses has been elected to the national board. This is indeed an honor.

There is one very important point that I wish to stress to you and that is, "if it weren't for the practical nurses in the hospitals and other job situations where practical nurses are employed, the patients would not be receiving the kind of care they are getting." You have contributed a hundred fold in upholding the high standards of quality nursing in our community.

Besides your educational growth through organizational activities, there are various educational opportunities here in the Islands for our nurses. Take advantage of these learning opportunities. As Janet Geister, a well known nurse leader of this country, pointed out in one of her articles, "Education must be a continuous process that brings forth both delight and profit up to

the day we die if we are to fulfill God's purpose and our own, and if we are to ripen instead of age."

Another well known figure once said these words, and I quote: "Our field of learning is around us every working moment, and the test lies in our ability to recognize and exploit our learning opportunities. Growing a life is more important than earning a living." Therefore, dear friends, read, subscribe to your magazines, attend your association meetings as faithfully as you can, enroll in some form of educational program. All of these will enrich your life.

This is certainly an appropriate time to remind that there is a day coming when all of us turn to Thanksgiving—a holiday whereby we express our gratitude for many blessings bestowed upon us.

A great man, Henry Van Dyke, stated these words which exemplify the true meaning of that memorable day: "Be glad to live, because it gives you the chance to love and work and to play, and to look up to the stars; to despise nothing in the world except falsehood and meanness, and to fear nothing except cowardice; to covet nothing that is your neighbors except his kindness of heart and gentleness of manners, to think seldom of your enemies, often of your friends and every day of Christ."

So in closing may I say that to fulfill ourselves truly, we must count our blessings and grow a life of happy usefulness. We must learn the joy of unselfish dedication to those less fortunate who look to us for understanding and comfort.

District and Section News

MINUTES OF THE PRIVATE DUTY NURSES SECTION

The Private Duty Nurses Section met on November 9 at 3:30 P.M. with 20 members present. Meeting was called to order by the Chairman, Mrs. Esther Kikukawa.

1) Mrs. Kikukawa explained that private duty nurses may ask the NATH Board for an advisory committee. Such a committee would serve to aid in solving problems of physical and economic nature of private duty nurses. A motion was made which was seconded and carried to ask that such a committee be appointed.

2) A letter from ANA requesting for suggested topics for the program of national convention to be held in Atlantic City in 1958 was presented. A suggestion was made to request films and lectures on recent advancement in cardiac surgery.

3) Salary increase was discussed and Miss Hamilton was asked to appoint a committee of two to work with her on research of economic standards and later to submit a letter to the board regarding salary adjustment. Mrs. Alexander and Miss Jonsrud were appointed to this committee. There was also discussion on the subject of full pay for partial day of work and deletion of partial clause on statements.

4) Election of officers was held. The following were nominated and elected to various offices:

Chairman, Miss Elvera Hamilton.
Vice Chairman, Mrs. Claire Winter.
Secretary, Mrs. Donna Imai.
Nominating Committee, Miss Elizabeth Erwin, Chairman; Mrs. Kimiyo Kondo, Mrs. Elsie Hodges.
Members-at-Large, Mrs. Eleanore Alexander, Mrs. Louise Schleif.

The meeting was adjourned at 4:30 P.M.

DONNA IMAI, R.N.
Secretary

INSTITUTIONAL NURSING SERVICE ADMINISTRATORS SECTION OF THE NURSES' ASSOCIATION, TERRITORY OF HAWAII, INC.

September 20, 21, 22, 1956

The meeting of the INSA section was called to order by Mrs. Eleanor Apo, chairman, at Mabel Smyth Building. The minutes of the last annual section meeting were read and approved. Miss Eunice Graham was appointed Chairman of the Tellers, with Mrs. Bernadette Nakahata and Mrs. Elizabeth Stillman assisting.

Committees and Executive Council Reports:

1. The report of the Nominations Committee was read by Mrs. Dorothea McClintic and approved by the members:

Chairman—2 year term, Hilda Ferrick, Elaine Johnson
Member-at-Large—2 year term, Marie Cheek, Hisae Neidenberg, Sara Trainovich, Laurietta Walser.

2. Report of the Rules Committee.

The Proposed Revisions of Rules were read and adopted.

3. Executive Council Report.

Mrs. Apo announced that Mrs. Gladys Jacobs of Hawaii attended the INSA section meeting during the ANA Convention in Chicago, and a total of $56 had been received from the members to defray expenses. Mrs. Jacobs' report of the convention appeared in the June issue of the NATH Newsletter.

Announcement:

$2 million is available to nurse administrators and supervisors for advanced study—Health Amendments Act of 1956. Full information plus a list of approved schools for such study have been circulated to directors of nursing and also will appear in the December issue of the Inter-Island Nurses' Bulletin.

Old Business:

The possibility of a workshop for this section was discussed. Miss Wigen reported on her meeting with Miss Margaret Giffin of ANA in connection with the feasibility of such a workshop next fall on supervision for supervisory groups. This is dependent on ANA's timetable and would cost approximately $35 to $75 per person. The members listed the following specific areas to be covered in the workshop.

1. Inservice training.
2. Staffing patterns and nursing service budget.
3. Supervisory technics and evaluation of work performance, including nursing audits.

4. Evening and night supervision.
5. Work improvement methods including simplification of nursing service records.

The group felt strongly that Central Supplies and Operating Room supervision should *not* be included in this workshop; however, if indicated there should be one held the following year in these two areas, a copy of the above list will be sent to Miss Mary Marshall of the Hospital Council as requested.

The national INSA program committee has requested suggestions for 1958 Biennial. Members of this section have been asked to send in suggestions to our new chairman by November, 1956.

A pamphlet called *What Good Nursing Care Means To You* was referred to the Executive Council for review and/or purchase.

A request from NATH Board for "refresher courses for nurses" was referred to this section for consideration. The following were appointed to investigate this matter: Miss Margaret Nott, Mr. Lawrence Katsuyama and Mrs. Mildred Kim.

Mrs. Judith Whitaker, Deputy Executive Secretary from ANA, met with this section. She reviewed the purpose of this section which is to improve the practice in administration and supervision. She stated that there is a reluctance and some resistance regarding economic security for supervisors and administrators. She reminded the group of the need to be more realistic in view of the services rendered and the necessary preparation for nursing administrators and supervisors. We need to determine the needs and interests of the members of this section in terms of improvement in employment conditions and salary. If compensations are adequate, perhaps we should strengthen our program through workshops. She reminded us that ANA never operates on the principle that it tells the state sections what to do; rather, it suggests ways for setting up employment conditions which may be adopted as minimum. These may be circulated to the employers after approval by state section and the state Board of Directors. For such policies to be effected we can legislate and consult with Civil Service. Such a program is based on the premise that the members want an Economic Security program.

An interesting discussion followed on mutual problems of nursing administrators and as a result it was decided that we ask the Executive Council to organize a branch in our section for Directors of Nursing Service; also a branch for Assistant Directors and one for Supervisors if there is a demand for these branches.

The report of the tellers was given as follows:

Chairman, Elaine Johnson.
Member-at-Large, Sara Trainovich.

Other officers for 1956-1957 are:
Vice Chairman, Patience Martelon.
Secretary, Mildred Kim.
Member-at-Large, Rachel Kong.

The last meeting of the section was adjourned on Saturday, September 22, 1956, at 9:30 A.M.

MILDRED KIM, R.N.
Secretary

INDUSTRIAL NURSE SECTION MEETING

Saturday, September 22, 1956
Mabel Smyth Building

The Industrial Nurse Section meeting was called to order by Mrs. Marjorie Okinaka, vice chairman, at 8:15 A.M.

Present: Helen Kluegel, Georgeana Pennypacker, Oahu; Mary Tully, Mary Nailau, Nettie Morimoto, Hawaii; Marjorie Okinaka, Eileen MacHenry, Maui; Helen Hetrick, Grace Oliver, Kauai.

Mrs. Judith Whitaker, deputy executive secretary of ANA, met with the group.

The survey of "Salaries and Employment Conditions of Registered Nurses Employment by Industries in Hawaii" was reviewed. The section's next step is to procure similar information for other nurses and professional groups and data on the cost of living. After obtaining these facts, the section will then be able to set up minimum standards for industrial nurses.

It was felt that interest in the industrial section could be stimulated by getting more information to the nurses. One way could be to use the *Inter-Island Nurses' Bulletin* and the Newsletter as a media of communication. It was felt that the district representative for the section might check with the members of her island to see whether they were receiving "Notes and Quotes for Industrial Nurses." Members should check with their district treasurer to be sure that they are listed as members of the industrial section.

Motion: It was moved by Miss Oliver and seconded by Miss Tully that the section ask NATH for funds to be used for section expenses. The motion was carried.

Because the section meets once a year only, it was felt that more time should be alloted for meetings during the convention. Workshops such as working on minimum employment standards could be held with all islands represented.

Motion: It was moved by Miss Morimoto and seconded by Miss Nailau that the section ask for longer meetings at future conventions. The motion was carried.

Motion: Miss Hetrick moved that in the future, the chairman and the secretary be nominated from the same district to facilitate section business between meetings. This motion was seconded by Miss Oliver and carried.

Motion: It was moved by Miss Morimoto and seconded by Miss Oliver that the meeting be closed at 9:30 A.M. The motion was carried.

* * *

Friday, September 22, 1956
Mabel Smyth Building

The annual meeting of the Industrial Nurse Section was called to order by Mrs. Marjorie Okinaka, vice chairman, at 10:30 A.M.

Present: Mary Tully, Nettie Morimoto, Mary Nailau, Hawaii; Grace Oliver, Helen Hetrick, Kauai; Helen Kluegal, Lois Bell, Oahu; Eileen MacHenry, Marjorie Okinaka, Maui.

Minutes from the last annual section meeting were read and approved.

Miss Nailau, nomination committee chairman, reported that all ballots had not been returned.

Miss Nailau reported the following:

Vice Chairman, Gerda Rutherford, Oahu, 1956-1958.
Nominating Committee, Marguerite MacDermid, Oahu; Mary Tully, Hawaii; Katherine Irwin, Kauai; Eileen MacHenry, Maui.

The chairman's report was read by Mrs. Okinaka. There were no reports from the standing committees.

The $25 requested at the last convention was not used and was returned to the NATH General Fund.

Mrs. Marjorie Okinaka read the Maui District Industrial Section report. The dissolution of the Maui section was reported at the NATH Board meeting in June.

Two memoranda from ANA concerning topics and participants for the 1958 ANA Industrial Section meeting and the availability of scholarships under the Health Amendments Act were read. It was felt that members present inquire other members what they would like for a program and the suggestions be forwarded to Mrs. Edna Baldwin, chairman.

Miss Oliver made the motion, seconded by Miss Nailau that the Industrial Section request help from other industrial associations in sending a delegate to the 1958 ANA Convention.

Functions, Standards and Qualifications for an Industrial Nurse in a one-nurse service were discussed by the group. It was felt that copies should be sent to the management. These may be obtained by writing to the ANA Industrial Nurse Section, 2 Park Avenue, New York 16, New York.

It was felt by the group that a monthly or bi-monthly newsletter would help to stimulate interest in the NATH Industrial Nurse Section.

Other topics discussed by the group were: "The Nurse as a Member of the Safety Committee" and "Transportation of Patients."

It was moved by Miss Nailau and seconded by Miss Hetrick that the meeting be closed at 11:35 A.M. The motion was carried.

H. EILEEN MACHENRY, R.N.
Acting Secretary

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NOTES AND NEWS

(*Continued from page 297*)

1957 Mississippi Valley Medical Society Essay Contest

The attention of physician medical writers is called to the Mississippi Valley Medical Society Annual Essay Contest. Any subject of general medical or surgical interest including medical economics and education may be submitted providing the paper is unpublished and is of interest and applicable value to general practitioners of medicine. Contributions are accepted only from physicians who are members of the A.M.A. Manuscripts must not exceed 5,000 words and be submitted in 5 complete copies, in manuscript style. The winning essay receives a cash prize of $100.00, gold medal, and a certificate, also an invitation to address the annual meeting of the Mississippi Valley Medical Society. Essays must be in the office of the M.V.M.S. Secretary not later than May 1, 1957. Winning essays are published each year in the January *Mississippi Valley Medical Journal* (Quincy, Ill.).

Stanford Postgraduate Conference in Ophthalmology

Stanford University School of Medicine will present the annual postgraduate conference in Ophthalmology from March 18 through March 22, 1957. Registration will be open to physicians who limit their practice to the treatment of diseases of the eye; or eye, ear, nose and throat. In order to allow free discussion by members of the conference, registration will be limited to thirty physicians.

Instructors will be Dr. David L. Bassett, Dr. Jerome W. Bettman, Dr. Max Fine, Dr. Earle H. McBain, Dr. Arthur J. Jampolsky, and Dr. Dohrmann K. Pischel.

Programs and further information may be obtained from the Office of the Dean, Stanford University School of Medicine, 2398 Sacramento Street, San Francisco 15, California.

Meetings

Hawaii

Hawaii Medical Association
Annual Meeting—Lihue, Kauai—May 2 to 5, 1957
Pan-Pacific Surgical Association
Triennial Meeting—Honolulu—November 14 to 22, 1957

Mainland

CALIFORNIA

American College of Chest Physicians—San Francisco—February 25 to March 1
College of Medical Evangelists School of Medicine—Los Angeles—March 10 to 14
American Congress of Physical Medicine and Rehabilitation—Los Angeles—September 8 to 13
California Medical Association Series (for information on later meetings call 5-7907)
Symposium on Cerebral Palsy—San Francisco—March 2
Surgical Forum—Los Angeles—March 4 to 8
Postgraduate Institute—Carmel—March 7 to 8
Surgery in Acute Trauma—Letterman Army Hospital—April 1 to 3
International College of Surgeons Regional Meeting—Santa Barbara—April 1 and 2
Valley Children's Hospital Spring Clinics—Fresno—April 12 and 13
Annual Meeting—Los Angeles—April 28 to May 1

GEORGIA

Medical Association of Georgia—Annual Meeting—Savannah—April 28 to May 1

IDAHO

California Society of Anesthesiologists, Inc.—Annual Meeting—Sun Valley—April 9
Idaho State Medical Association—Annual Meeting—Sun Valley—June 16 to 19

ILLINOIS

Institute on Rehabilitation Center Planning—Chicago—February 25 to March 1

LOUISIANA

Fats in Human Nutrition—AMA Symposium—New Orleans—March 15
American College of Surgeons Sectional Meeting—New Orleans—February 4 to 7

MASSACHUSETTS

The American College of Physicians—Annual Session—Boston—April 8 to 12

MINNESOTA

American College of Surgeons Sectional Meeting—St. Paul—April 8 to 10
Minnesota State Medical Association—Annual Meeting—May 13 to 15

MISSOURI

National Tuberculosis Association—Annual Meeting—Kansas City—May 6 to 9

NEW JERSEY

The American College of Physicians—Annual Session—Atlantic City—April 28 to May 2, 1958

NEW YORK

Pan American Eye Specialists Congress—New York City—April 7 to 10

OHIO

The Academy of Medicine of Cincinnati—Cincinnati—February 27 to March 5

PENNSYLVANIA

American College of Chest Physicians Postgraduate Courses—Philadelphia—April 1 to 5

TENNESSEE

Institute of Nuclear Studies Seminars on Thyroid-Uptake Measurement—Oak Ridge—March 18 and 19, April 15 and 16, May 17, and June 10 to 14

TEXAS

United States-Mexico Border Public Health Association Annual Meeting—San Antonio—April 9 and 12

WASHINGTON

American College of Surgeons Sectional Meeting—Seattle—February 28 to March 2
Washington State Medical Association Annual Meeting—Seattle—September 15 to 18

WYOMING

Wyoming State Medical Society Rocky Mountain Medical Conference—Moron—September 15 to 18

WASHINGTON, D. C.

American College of Surgeons Sectional Meeting—March 18 to 20 (*Continued on page 316*)

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NOTES AND NEWS

(*Continued from page 314*)

Sixth International Congress of Otolaryngology—May 5 to 10
World Congress of Gastroenterology—May 25 to 30

Foreign

AUSTRIA

International Society for Hygiene and Prophylactic Medicine on University and Public Health—Vienna—May 31 to June 2

CANADA

American College of Surgeons Sectional Meeting—Toronto—March 25 to 27
The Ninth International Congress on Rheumatic Diseases—Toronto—June 23 to 28

ENGLAND

International Congress on the Circulation—London—June 3 to June 8
International Cancer Congress—London—July 6 to 12, 1958

MEXICO

Pan American Medical Association Inter-American Congress—Mexico City—April 15 to 21

GUATEMALA

Pan American Medical Association Inter-American Congress—Guatemala City—April 22 and 23

THAILAND

Ninth Pacific Science Congress—Bangkok—November 18 to December 9

TURKEY

World Medical Association—General Assembly—Istanbul—September 29 to October 5

AMA Meetings

June 3 to 7, 1957—New York City
December 3 to 6, 1957—Philadelphia
June 23 to 27, 1958—San Francisco
December 2 to 5, 1958—Minneapolis

Correspondence

Con Man

Dr. Webster Boyden
Hawaii Medical Association
Honolulu, Hawaii

Dear Dr. Boyden:

There seems to be a lone confidence man operating on the West Coast who is victimizing the doctors and druggists. To get into the confidence of his victims he is bringing the name of McKesson & Robbins into his presentation.

His method of operation is as follows: The man, who in the first instance called himself Elmer C. Clark, contacted a physician's office in the Los Angeles area and presented a plan to supply doctors with a permanent phone book. The phone book which was shown as a sample had the words "Presented by McKesson & Robbins, Inc." on it. In his presentation, Mr. Clark stated that our company had taken an ad in the book and were going to take part in the distribution of it. Our company of course has no part in this and he is using our name without our consent or knowledge. Another part of the plan was to supply a picture postcard mailing. The contract required a $50.00 deposit. This Los Angeles victim paid the $50.00 deposit and after several days called the phone number Clark had given to inquire about delivery. They were advised that there was no such telephone number.

This first appearance happened several months ago, and we now find that a similar presentation has been made to a San Leandro Physicians' Exchange. However in this case the man, who called himself Grant, hurriedly left his interview when a telephone call interrupted.

Of course this operation is still on the West Coast, but it is very possible that since things are getting warm for this individual on the Coast, he could shift his operations to Hawaii.

With the thought that you might care to forewarn your membership, we are giving you this information.

McKesson & Robbins, Incorporated
L. H. Long
Sept. 27 *Division Manager*

Fan Mail

To The Editor:

It is a great pleasure to renew my subscription to the Journal for another year. Each issue is read with attention from cover to cover, as my only means of keeping up with the doings of the many men in the Territory I remember with pleasure from my tour at Tripler. Not only the Centennial issue, but each issue as it arrives is a potent reminder of the high quality of medical practice in Hawaii, and a stimulus to do as well here in Quincy.

It is interesting to reflect on the fact that the trade area of this Mississippi river town is about 300,000 population, or about equal to Oahu, yet in Honolulu in all branches of medicine there seem to be more cases of unusual and intriguing illness in all fields of medicine. Approximately 100 doctors serve our people here, and the level of care is high. I feel certain that missed diagnoses of significance to the patient's general welfare are very infrequent. It is a great rarity for anyone here to see a patient requiring radical neck dissection, for example, yet I recall seeing a number of such cases posted in a short time in Honolulu. It would perhaps make an interesting demographic study to compare the incidence of certain diseases in approximately equal populations of relatively great stability (excluding the transient Service population in Honolulu).

With all best wishes for the continued success of the Journal, I remain

Donald M. Wright, M.D.
Oct. 23

Science Congress

To The Editor:

The Bishop Museum, as Representative Institution of the Pacific Science Association in Hawaii, has been asked by the President of the Ninth Pacific Science

(*Continued on page 330*)



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IN MEMORIAM

(*Continued from page 287*)

Hong Kong, China, to sea to free it of smallpox. The vessel was at sea ten days and on its return was pronounced free of disease by the Hawaiian health authorities.

Dr. Mouritz spent four years at Kalaupapa, where he was a co-worker with Father Damien. The following twelve years he spent on leeward Molokai, where he continued to act as consulting expert to the Kalaupapa settlement. He served as an expert inspector of the Goto leprosy treatment from 1893-1895, and it was his opinion that the treatment, which at that time had given hopes of great beneficial results, was more harmful than helpful. Eventually the treatment was discontinued.

Besides a history of leprosy (*The Path of the Destroyer*), which he published in 1916, and which is now a collector's item, Dr. Mouritz wrote the following: *Historical Castles*—London, 1882; *The Tragedy of the Careless*—Cincinnati, 1906; *Brief World's History of Influenza*—Honolulu, 1920; *The Conquest of Smallpox*—Honolulu, 1924; and *Our Western Outpost*—Honolulu, 1935.

In 1938, because of his intimate association with Father Damien, Dr. Mouritz was the principal witness before the ecclesiastical court held here on the life work of the "Martyr of Molokai."

Dr. Mouritz died on December 1, 1943. He was survived by a son, Desmond, and a daughter, Nora.

The following is quoted from the obituary published in the *Hawaii Medical Journal* of March-April 1944: "Dr. Mouritz was a man of courage, but he was extremely anti-social. He was not a member of organized medicine, but was given an honorary membership by the Honolulu County Medical Society in 1934. His friends were very few but to those he was very loyal. He was of a very retiring disposition, and in the last years of his life in Honolulu he lived alone in a cottage off Vineyard Street practicing medicine among the poor, giving freely of his time, services and medicine to those who cared to come to him. Very proud, and of an independent spirit, he refused any help from his fellow physicians, often giving away to his patients or neighbors what was given to him by others. Nothing was more difficult than to take care of him during his last illness. Dr. Mouritz's life was an unselfish one and one of good deeds."

Charles Allen Peterson*

Charles Allen Peterson was born on November 9, 1857, at Sandwich, Massachusetts. He came to Honolulu with his parents, sister and brothers, in September, 1870, as a boy of twelve.

He received his high school training at Punahou, being prepared for Amherst College by Frank Damon, Amherst graduate, son of Rev. S. C. Damon of the Bethel Chapel. He received his A.B. from Amherst in 1879 and his M.A. in 1880, and then attended the medical school of the University of Michigan at Ann Arbor. He transferred from this medical school in his last year, and his degree of M.D. in 1884 came from the New York College of Physicians and Surgeons, now part of Columbia University.

Returning to Honolulu in August, 1884, with his bride, Susan Jennings (Mt. Holyoke, 1879, daughter of the Rev. Wm. Jessup Jennings of Redding, Conn.), he was assigned by King Kalakaua as government physician to the Kaneohe and Koolau districts. He was especially valuable in this area, as he spoke Hawaiian fluently. In 1886 he went to California and took a short course at Cooper Medical (now Stanford Medical School and hospital) and practiced for a year in Santa Cruz, California.

In 1888 he returned to Honolulu and became resident physician at Kalaupapa Settlement for the next year. Feeling that the leprosy settlement was an unsuitable place to raise his children, he returned to Honolulu and engaged in private practice, although he made many trips of inspection for the government to Kalaupapa and his interest in leprosy never flagged. He was one of the first to point out the similarity between the causative agent of leprosy and tuberculosis—for which he was laughed at.

His practice and work was largely among the Hawaiians. In 1894 he spent a few months as plantation physician at Ewa.

In December, 1899, again in private practice, he volunteered his services in the bubonic plague epidemic of that time, and lived in quarantine away from his family with the other volunteer doctors in the old building, now demolished, behind Iolani Palace. He also was one of the few doctors who volunteered to be injected with the new plague serum which was then being used experimentally.

In 1905 he was appointed as resident physician at the Insane Asylum where his knowledge of Hawaiian and smattering of Japanese and several Chinese dialects obtained on the plantations, served in good stead. He died of meningitis while still physician at the Insane Asylum, on January 1, 1913.

At the Asylum, he initiated a program of hydrotherapy, and a varied and balanced diet, and insisted that each patient spend most of every pleasant day out of doors. Heavy wooden chairs were made which confined the most violent patients and they, too, were given the fresh air treatment and sun baths.

* Written by Mrs. Simes T. Hoyt, daughter of Dr. Peterson.

George Henry Martin

George Henry Martin received his M.D. degree from Boston University School of Medicine in 1881.

In the same year Dr. Martin began his medical practice in San Francisco. At one time he was Professor of Mental and Nervous Diseases at Hahnemann Hospital.

For five years Dr. Martin lived in Honolulu and served as personal physician to King Kalakaua and his family. In 1888 he returned to the Coast.

Dr. Martin died December 16, 1944, in Pasadena, California, at the age of 85.

John Borland

John Borland was born in Greenock, Scotland.

He studied medicine at Glasgow University. While he was an undergraduate he acted as prosector to the professor of anatomy. Upon graduation he became home surgeon in the Glasgow Royal Infirmary to Dr. Perry and to Dr. Macewan, a man of world-wide fame.

After gaining much practical experience thus, Dr. Borland began practice in Islington, London. He was building up a good practice when his health failed and he was compelled to leave London and seek a more genial climate in Hawaii.

(*Continued on page 320*)

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IN MEMORIAM

(*Continued from page 318*)

Dr. Borland came to Kilauea, Kauai, in 1883, having received appointment as government physician to the northern district. About 1884 he moved to Waimea. Dr. Borland was married and had two children. On July 21, 1887, Dr. Borland died at Waimea.

"By his death the community of Kauai has lost at once a faithful and a skillful servant; and those who know him better, a genial companion and a kind-hearted and true friend," said an article in *The Hawaiian Gazette* of August 2, 1887.

Sidney Ernest Craddock

Sidney Ernest Craddock was born in India on November 8, 1859.

He was a member of the Royal College of Surgeons and the Royal College of Physicians, London.

In 1884 he came to the Islands as surgeon on the Portuguese immigrant vessel "Dacca," the immigrants under his care all arriving in splendid health.

For nearly two years Dr. Craddock served as government physician for the district of Hanalei, Kauai.

On May 4, 1887, he married Miss Webster in Honolulu.

Dr. Craddock died July 25, 1889, in Kilauea, Kauai, at the age of 29.

John Hancock Kimball

John Hancock Kimball was a graduate of Harvard Medical School in 1857.

About 1884 he was government physician for the Hilo district, and about 1890 he was in charge of the Honolulu city dispensary.

Dr. Kimball died at his home in Bridgeton, Maine, in 1902.

THIS IS WHAT'S NEW

(*Continued from page 284*)

upon the secondary changes in the myelin to looking at the more primary changes in the glial cells. *Science News Letter* (Oct. 27) 1956.

* * *

Ammonia intoxication, as an important causative factor in **hepatic coma,** has been recently emphasized. Last month the case of a patient with congestive heart failure who developed symptoms of hepatic coma after receiving **ammonium chloride** was reported. A liver biopsy showed only minimal fatty infiltration, but the clinical picture after he had received 6 grams of ammonium chloride a day for several days was that of hepatic coma with fetor hepaticus, stupor, and a flapping tremor of the hands. He expired after deep coma with elevated blood ammonia. *New Eng. J. Med.* (Nov. 8) 1956.

FRED I. GILBERT, JR., M.D.

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Behne, D.; Clork, F.; Jennings, M.; Pollois, V.; Olson, H.; Wolf, L., ond Tyler, E. T.: West. J. Surg. 64:152, 1956.

Composition: nonylphenoxypolyethoxyethanol 5% in on oil-in-woter emulsion ot pH 4.5.

HAWAII MEDICAL ASSOCIATION

(*Continued from page 298*)

majority of the Board of Directors) by the medical profession. Action No. 3 above is apparently relevant.

HARRY L. ARNOLD, JR., M.D.
Delegate

House of Delegates Meeting

November 2, 1956, Mabel Smyth Building

PRESENT: Dr. Boyden, presiding: Drs. Yee, Felix, Mitchel, Kuhlman, Nishijima, H. Q. Pang, Fronk, Morgan, Woo, Bennett, Johnsen, Sexton, Wilkinson, R. G. Benson, T. Y. K. Chang, Gilbert, Edmund Ing, L. Q. Pang, Quisenberry, Bailey, Herbert Chinn, Holmes, Batten, Elmer Johnson, Randal Nishijima, Edmund Lee, Sugihara, Yamauchi, and (by invitation) Mr. Richard Kennedy.

Alternates Johnsen, Wilkinson, Sexton and Nishijima were appointed by Dr. Felix to act for absent delegates.

MILITARY DEPENDENTS: Dr. Boyden gave corrected figures for military dependents on Kauai, as follows:

	WIVES	CHILDREN
Army	2	6
Air Force	1	2
Coast Guard	12	20
	15	28

Dr. Mitchel gave corrected figures for Hawaii, as follows:

	WIVES	CHILDREN
Kilauea Military Camp	36	79
Navy	3	5
Marine Corps	1	0
Army	3	10
Coast Guard	16	25
National Guard	11	27
	70	146

MEETING CALL: Dr. Boyden read the following letter requesting the meeting be called:

> The undersigned members of the House of Delegates of the Hawaii Medical Association, in accordance with Chapter VI, Section 2 of the Bylaws of this Association, hereby request that a special meeting of the House of Delegates be called to clarify the selection of the Bureau of Medical Economics as the fiscal administrator for the Hawaii Medical Association in their contemplated contract for the Military Dependency Care Program. It is suggested and hoped that this meeting be called during the week prior to November 4, 1956, as both our President and Mr. Kennedy will be leaving on that date or shortly after.
> 10/23/56
>
> JOHN M. FELIX, M.D.
> ANDREW MORGAN, M.D.
> THOMAS BENNETT, M.D.
> ROBERT BAILEY, M.D.

MEDICARE

Dr. Felix explained that the request was made because he and others had not realized at the previous meeting that the resolution might have failed to clarify the objection that naming the Bureau of Medical Economics as Fiscal Agent for Medicare might affect the other county societies unfairly. He then read the following resolution:

WHEREAS, The House of Delegates of the Hawaii Medical Association has approved the HMA as the contracting party in the Military Dependents' Medical Care Plan for the members of this association; and

WHEREAS, It was the intent of the House of Delegates that the Bureau of Medical Economics administer this program for the HMA; and

WHEREAS, After legal consultation and a meeting of a special committee appointed by the HMA president, Dr. Boyden, it would be much more feasible economically and legally to have the Bureau of Medical Economics appointed as the Fiscal Administrator instead of a subcontractor; and

WHEREAS, There is no representation of the Maui, Kauai, and Hawaii County Medical Societies on the Executive Committee or the Board of Directors of the Bureau of Medical Economics; and

WHEREAS, Although there will be no profits to be made directly by the Fiscal Administrator, there may be certain advantages derived in the administration of the Military Dependents' Medical Care Plan; therefore be it

Resolved, that

1. The House of Delegates hereby separately designates the Hawaii Medical Association as the Contracting Agent, and the Bureau of Medical Economics as the Fiscal Administrator in the Military Dependents' Care Plan; and that
2. Dr. Boyden and Mr. R. Kennedy be authorized to negotiate and sign contracts in behalf of the Hawaii Medical Association and the Bureau of Medical Economics as Contracting Agent and Fiscal Administrator respectively; and that
3. A committee, consisting of the Executive Committee of the Bureau of Medical Economics and one representative each from Maui, Kauai, and Hawaii County Medical Societies, be formed to act as a Board of Trustees to determine administrative policies under this program and shall be known as the 'Medical Care Program Committee' of the Hawaii Medical Association; and that
4. Any advantages, directly or indirectly, that may be gained by the Fiscal Administrator, shall be equitably pro-rated to each of the four County Medical Societies or to projects that would benefit the entire territorial medical profession; and that
5. All reasonable expenses incurred by Dr. Boyden, Mr. Kennedy, the delegates and others in the negotiation of this contract with the United States Government, be reimbursed subject to the conditions of the contract and approval of the Medical Care Program Committee.

Dr. Kuhlman pointed out that the contract provided reimbursement only on a cost-plus, no-profit basis, with cost accounting, and that claims must be coded on IBM cards, and that the Bureau of Medical Economics could only guess at the probable cost of the operation.

Dr. Gilbert suggested identifying the office rather than naming the incumbent, in the second and fifth "resolveds." Dr. Felix agreed, and the Resolution was so amended.

Dr. Yee, when asked how much profit might be expected, replied that he thought the important thing was that we should take hold of this plan for reasons not now apparent, one being the possible future expansion of the plan to include other federal services. He felt we should maintain as much control over the plan's operation as possible.

ACTION:

The adoption of the Resolution was passed by an overwhelming majority.

A motion was then passed to authorize Dr. Boyden to "use his best judgment" in the event the Department of Defense should decline to accept the Bureau of Medical Economics as Fiscal Agent.

A motion was then passed authorizing Dr. Boyden to appoint the Hawaii Medical Association as Fiscal Agent in the event the Department of Defense rejected the Bureau of Medical Economics.

The meeting was adjourned at 9:00 P.M.

SATORU NISHIJIMA, M.D.
Secretary

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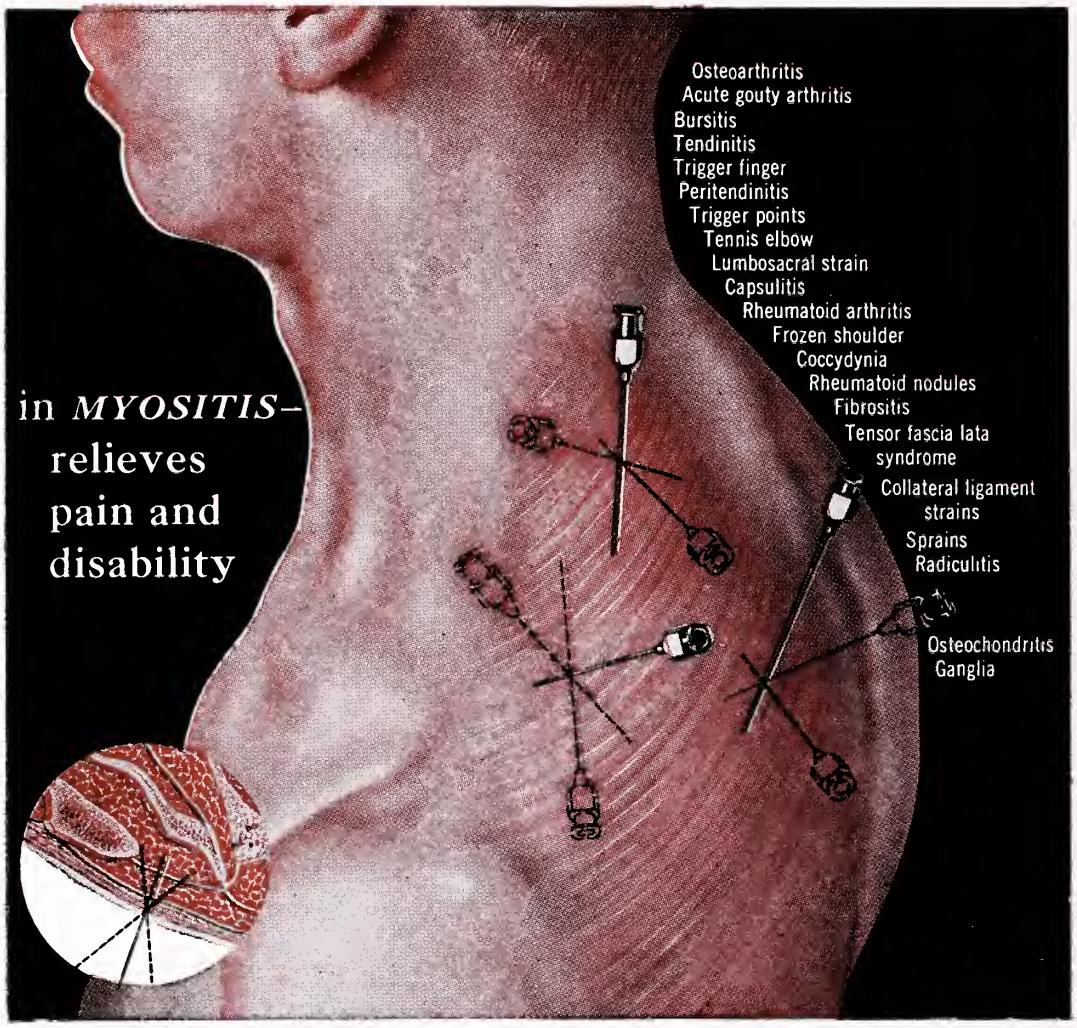
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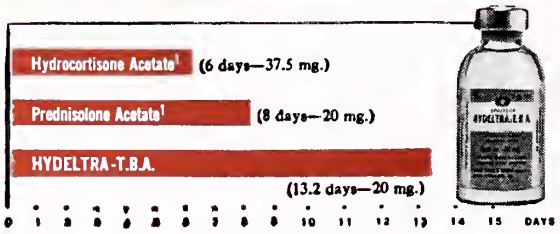
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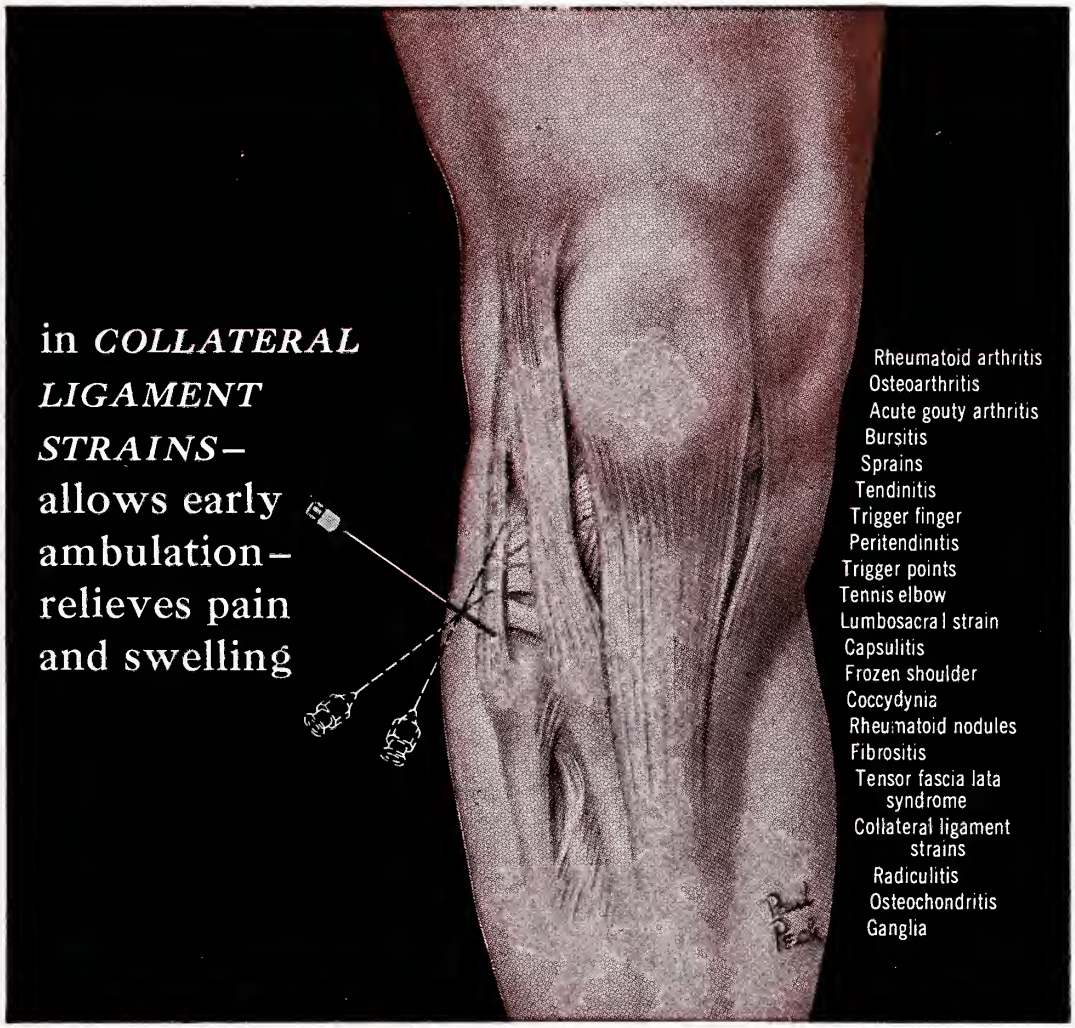
1. Hollander, J. L., *Paper read at conference in New York City, May 31 and June 1, 1955*

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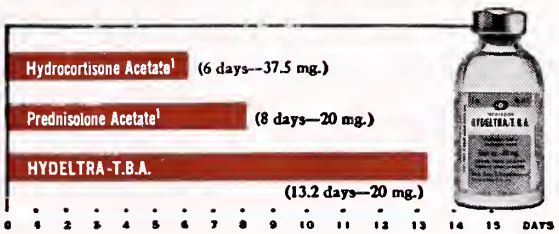
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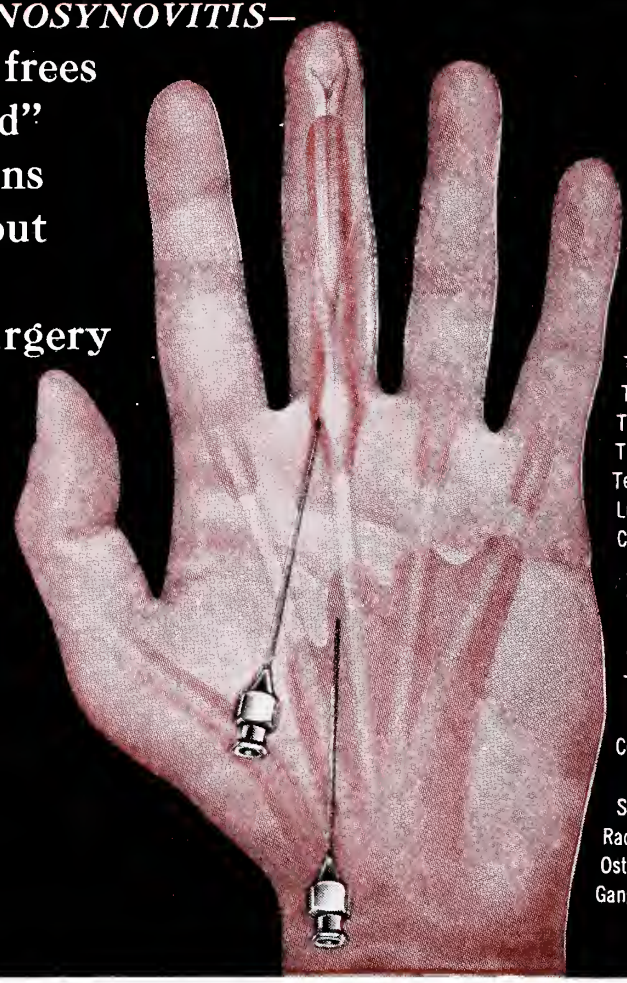
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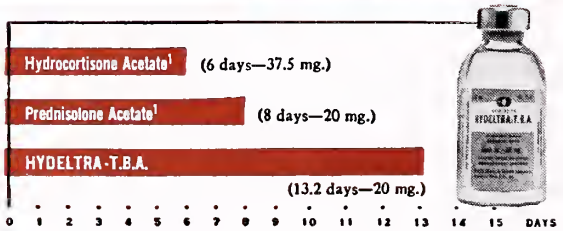
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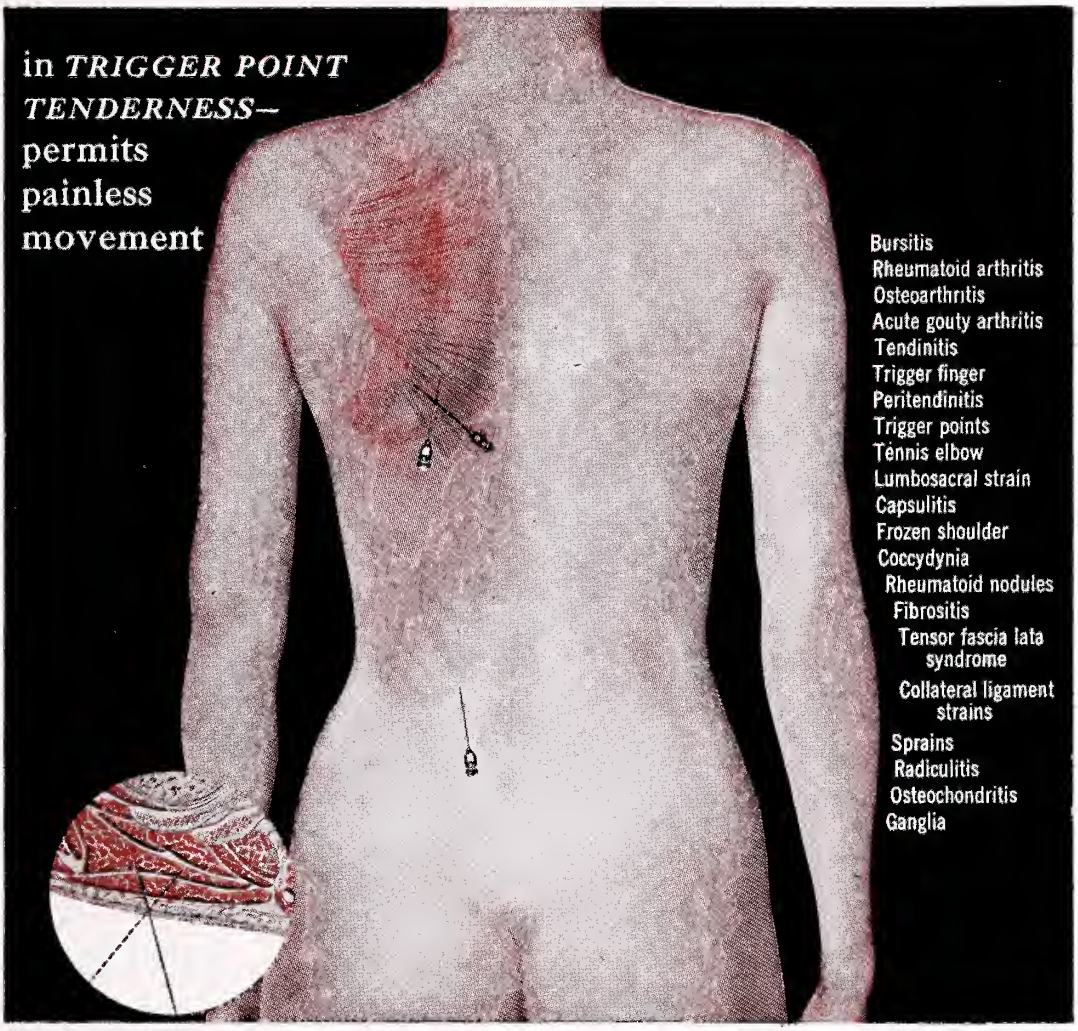
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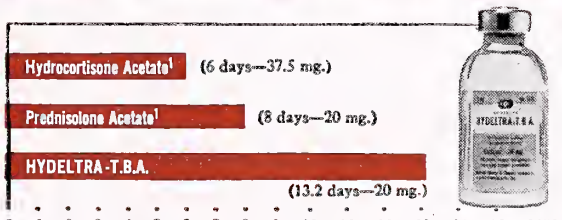
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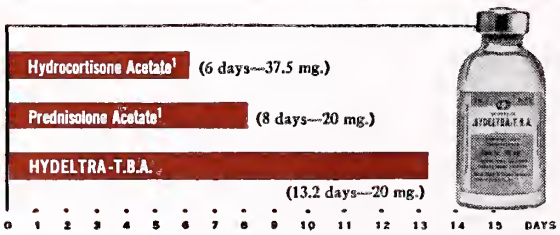
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in *SPRAINS*—
reduces tenderness,
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CORRESPONDENCE

(*Continued from page 316*)

Congress to extend an invitation to all scientists in Hawaii to attend the Congress, which takes place in Bangkok, Thailand, from 18 November to 9 December, 1957.

I should be grateful if you would take occasion at a forthcoming meeting of your organization to announce the dates of the Congress and advise your members where the attached Preliminary Announcement containing the outline program can be seen.

Bishop Museum has the responsibility for naming Hawaii's official delegation and I should appreciate your asking those of your members who plan to attend the Congress to let me know.

ALEXANDER SPOEHR
Director

Dec. 4

* * *

Residence Law Waivers

TO THE EDITOR:

The Board of Medical Examiners occasionally receives requests for waiver of the one year residence requirement on the behalf of unlicensed physicians who have been employed by plantations for rural areas. The Governor has the power to grant such requests upon favorable recommendation of the Board of Medical Examiners. In the past the Board has acted favorably upon such requests only when the request has been approved by the local county medical society.

The Board wishes to announce that in addition to approval of the local county medical society, such requests in the future will be granted only after an attempt has been made to procure a licensed physician locally by an appropriate notice of the vacancy in the Hawaii Medical Journal and in the county medical society bulletins.

I. L. TILDEN, M.D.
Secretary
Board of Medical Examiners

Dec. 21, 1956

* * *

Hungarian Refugee Physicians

THE
AMERICAN MEDICAL SOCIETY
OF VIENNA

D. H. Murray, M.D.
1136 Union Street
Honolulu, Hawaii

Dear Dr. Murray:

I acknowledge herewith and sincerely thank you for your communication of December 14, 1956.

With your permission, the money you will send will be applied for direct aid to the now more than 500 refugee Hungarian Doctors who are presently in Austria. Our Refugee Doctor's Organization is composed of:

1. Austrian Ärztekammer (Chamber of Physicians)
2. Vienna Society of Medicine
3. American Medical Society of Vienna

The Refugee committee selected by these three bodies consists of:

Prof. Dr. Felix Mandl, Professor of Surgery, University of Vienna
Prof. Dr. Leopold Schonbauer, Rector Emeritus of University of Vienna
Dr. M. Arthur Kline

We have, by experience, found that the best and most direct way to help our Hungarian Colleagues is to accord them $20.00 upon arrival, $10.00 for every week they remain in Austria, and $3.00 per day for board and lodging for those colleagues who have been designated to private quarters. We allot $1.00 per day for each additional member of the Doctor's family.

There are no organization or administrative expenses deducted. Every penny received is utilized for direct aid for our refugee Hungarian Colleagues.

I am profoundly grateful for your kind humanitarian gesture, which I assure you, will find full recognition in the practical assistance it provides for its needy beneficiaries.

Thankfully yours,

ANNA ENGEL-RANG, *Secretary*
for DR. M. ARTHUR KLINE,
Executive Secretary

11 Universitätsstrasse
Vienna, Austria
Dec. 22

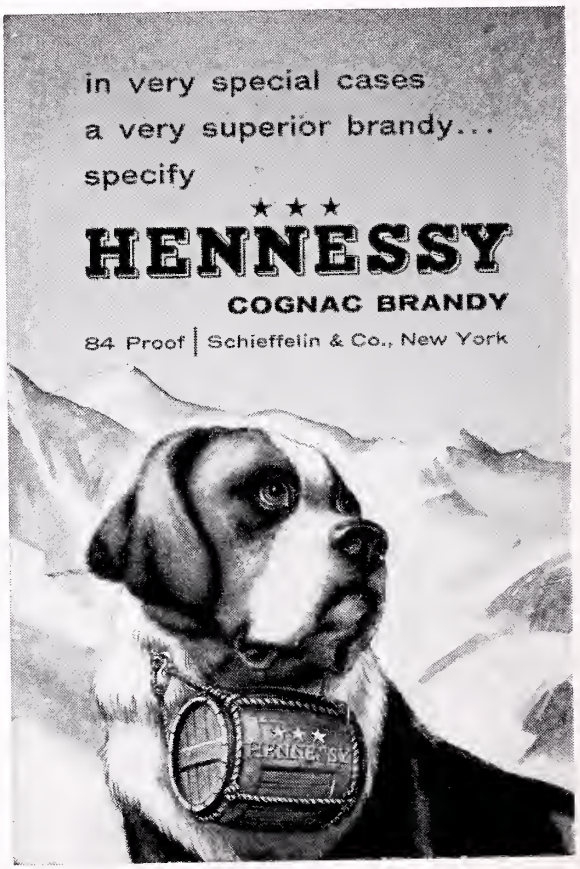
MEDICAL ECONOMICS

(*Continued from page 291*)

ant will most likely spend most of his time with the attending physician and not with the patient.

Remember that most fee complaints are based on the doctor's failure to explain his services, rather than the size of the fee. The Bureau has found that the consultation fee heads the list in this category.

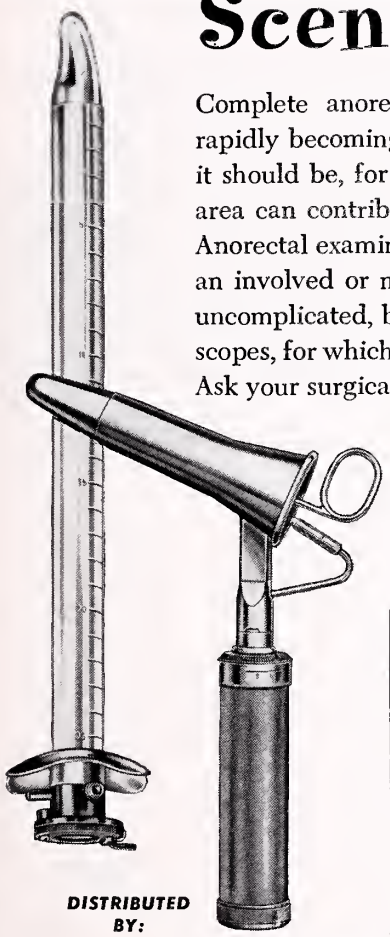
R. M. KENNEDY
Executive Secretary





Scene in your office?

Complete anorectal examination — digital, anoscopic, sigmoidoscopic — is rapidly becoming a part of every complete physical examination. This is as it should be, for every diagnosis of cancer and precancerous lesions in this area can contribute greatly to raising the present low percentage of cures. Anorectal examination, as many thousands of doctors have discovered, is not an involved or mysterious procedure. It is made even easier by the use of uncomplicated, brilliantly illuminated Welch Allyn anoscopes and sigmoidoscopes, for which your regular WA battery handle serves as the power source. Ask your surgical supply dealer to show you these practical instruments.



Copies of the helpful Welch Allyn booklets "Anal and Lower Rectal Lesions" and "Proctologic Examination" are available without charge from your WA dealer or from Welch Allyn, Inc., Skaneateles Falls, N. Y.

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Each INCREMIN TABLET *contains:*

l-Lysine	300 mg.
Vitamin B_{12}	25 mcgm.
Thiamine (B_1)	10 mg.
Pyridoxine (B_6)	5 mg.

(INCREMIN Drops contain 1% alcohol)

Remember INCREMIN DROPS. Same formula. Cherry flavor. Can be mixed with milk, milk formula, or other liquid. In 15 cc. polyethylene dropper bottle. *Dosage:* 0.5 to 1 cc. (10-20 drops) daily.

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*Reg. U. S. Pat. Off.

HMSA

(*Continued from page 290*)

Both physicians reported the vital need for participation in these work-shop conferences for they feel that the future course of the voluntary prepayment plans is blueprinted there. At such meetings invaluable information is provided and the views of representatives of all phases of business and labor on medical plan coverage are discussed and debated.

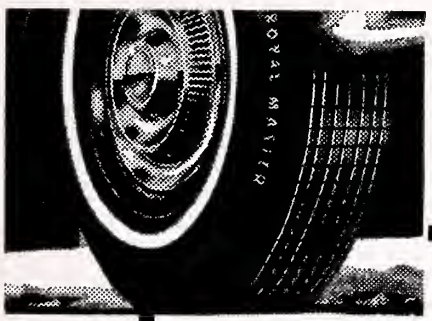
Medical plans are one of the most discussed subjects today throughout the United States. One can readily find articles in periodicals or newspapers which point toward possible Government medicine and other forms of medical plan coverage which do not maintain "free choice." It appears that the medical profession must retain its interest in HMSA and support its progress and advancement. It represents our true answer to the threat of socialized medicine or the infiltration of other types of medical plans which infringe on our present system of providing medical service.

The Medical Committee feels it has an interest in the medical profession to continue to exert full efforts to maintain HMSA as an effective medical plan which meets the need of the people of Hawaii. To assure full participation at all meetings, the Committee had recommended election of four alternate physician Directors to serve on the HMSA Board of Directors from the Honolulu County Medical Society. At present each of the neighbor Islands has an alternate Director which has resulted in an excellent attendance record at the Medical Committee meetings.

This year, sixteen physicians and the Executive Secretary of the Honolulu County Medical Society have attended as guests and have actively participated in the discussion of the Medical Committee. It is our hope that eventually every physician will have a chance to take an active part in the operations of the Association by being on the Board or become acquainted with the Medical Committee's responsibilities by attending their meetings as guests.

All members of the Medical Committee have spent much effort and time on the problems presented to them and they wish to acknowledge the cooperation they have received from the Medical Society. The Committee also wishes to pay tribute to the lay members of the HMSA Board of Directors who have contributed immeasurably to the successful operation of the Plan, and to congratulate the HMSA staff for maintaining a well-organized and economical operation, offering excellent service to the membership, hospitals, and the medical profession.

RODNEY T. WEST, M.D.
Chairman, Medical Committee



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COUNTY SOCIETY REPORTS

(*Continued from page 295*)

Washington, it was moved that the Honolulu County Medical Society support the recommendation of the Board of Governors which was to name HMSA as the fiscal agent for the Medicare Program. After some discussion, the motion was passed, with the recommendation that the House of Delegates be instructed of the action taken at this meeting.

There being no further business, the meeting was adjourned to the lanai where refreshments were served.

* * *

The annual meeting of the Honolulu County Medical Society was held on Tuesday, December 4, 1956, at 7:30 P.M. in the Mabel Smyth Auditorium. Dr. J. M. Felix presided and approximately 186 members were present.

Dr. Ichiro Nadamoto was welcomed into the Society as a new member.

The Nominating Committee's report was then read by Dr. Felix, following which the election of officers and elective committees was held. Adequate time was given for nominations from the floor and voting was by written ballot. Drs. Edwin Ballard, Angie Connor, P. Liljestrand, William Myers, J. Peyton, Robert Wong, W. Stevens, and Jack Woodruff were appointed by the President to act as tellers. The results of the election were as follows:

OFFICERS

Dr. Rodney T. West, *President-Elect*
Dr. Thomas H. Richert, *Secretary*
Dr. H. Q. Pang, *Treasurer*

BOARD OF GOVERNORS

Dr. James G. Marnie
Dr. Robert D. Millard
Dr. Richard D. Moore
Dr. C. Y. Sugihara

ALTERNATE BOARD OF GOVERNORS

Dr. Richard E. Ando
Dr. Herbert Chinn
Dr. Ivar Larsen

BOARD OF CENSORS

Dr. William Walsh

REPRESENTATIVES TO HMSA

Dr. J. W. Devereux
Dr. L. Q. Pang

FEE ADJUSTMENT COMMITTEE

Dr. E. F. Cushnie
Dr. David L. Pang

MEDICAL CARE PLANS COMMITTEE

Dr. Richard D. Moore
Dr. William Ito
Dr. F. L. Giles
Dr. Thomas Richert
Dr. Samuel Yee
Dr. John Bell

MEDICAL PRACTICE COMMITTEE

Dr. G. C. Freeman
Dr. C. K. Kobayashi

DELEGATES TO HMA

Dr. Morton Berk
Dr. William H. Gulledge
Dr. Edmund Lee
Dr. O. D. Pinkerton
Dr. H. M. Sexton
Dr. W. H. Wilkinson
Dr. Leabert Fernandez
Dr. Roy Tanoue
Dr. T. Fujii

ALTERNATE DELEGATES TO HMA

Dr. E. W. Boone
Dr. James W. Cherry
Dr. Albert Ishii
Dr. Charles Judd, Jr.
Dr. Edward K. Lau
Dr. Chew Mung Lum
Dr. Leon E. Mermod
Dr. K. Okazaki
Dr. M. E. Stevens

The annual committee reports were presented as follows, accepted and filed:

Report of the President-Elect—Dr. T. Nishigaya
Report of the Secretary—Dr. Rodney T. West
Report of the Treasurer and Finance Committee—Dr. T. H. Richert
Board of Censors—Dr. Wm. M. Walsh
Advisory Committee to the Woman's Auxiliary—Dr. W. J. Holmes
Constitution and By-Laws Committee—Dr. Richard C. Durant
Diabetes Detection Committee—Dr. T. Togasaki
Fee Adjustment Committee—Dr. F. L. Giles
HMSA Medical Committee—Dr. Rodney T. West
Legislative Committee—Dr. Theodore Tomita
Medical Care Plans Committee—Dr. Richard Moore
Medical Practice Committee—Dr. T. Nishigaya
Parliamentary Committee—Dr. C. Y. Sugihara
Postgraduate Committee—Dr. A. L. Vasconcellos
Program Committee—Dr. Homer R. Benson
Public Service Committee—Dr. Ellsworth B. Harris
Resolutions Committee—Dr. E. K. Chung-Hoon
Woman's Auxiliary to the Honolulu County Medical Society—Mrs. Homer Benson

The membership unanimously approved a vote of thanks to the Diabetes Detection Committee, Dr. West and the HMSA Medical Committee, and the Woman's Auxiliary to the Honolulu County Medical Society for a job well done.

Relative to the Dependents' Medical Care Program, the House of Delegates requested the reappraisal of the fiscal agent because of certain information recently brought back from the A.M.A. meeting by Dr. Arnold, Jr. This was discussed by the membership who reaffirmed its previous action, which was to name HMSA as the fiscal agent.

The membership gave final approval of the fee schedule submitted by the Fee Adjustment Committee and which would include certain recommended changes.

The report and recommendations of the Special Public Health Survey Committee, presented for approval, were unanimously accepted as amended.

The presidential address was then presented by Dr. J. M. Felix, following which Dr. Toru Nishigaya was duly installed as President of the Society.

There being no further business, the meeting was adjourned to the lanai where refreshments were served.

RODNEY T. WEST, M.D.
Secretary

Kauai

The regular monthly meeting of the Kauai County Medical Society was called to order at 7:30 P.M. on September 4, 1956, at the G. N. Wilcox Memorial Hospital library by the president.

Members present: Drs. Wallis, Masunaga, Wade, Kim, Fujii, Kuhlmann, Goodhue, and Schilling.

It was moved and seconded to approve of HMSA as agent to administer payment of the medical benefits under Public Law 569.

A committee was formed for the forthcoming diabetes detection drive. Dr. Kuhlmann, chairman, selected Drs. Kim, Masunaga and Schilling as committee members.

Chairmanships for the next Hawaii Medical Association meeting were named:

General Chairman	Dr. Wade
Co-Chairman	Dr. Masunaga
Reservations	Dr. Wallis
Scientific Program	Dr. Goodhue
Scientific Exhibits	Dr. Kim
Entertainment	Dr. Ishii
Transportation	Dr. Cockett
Publicity	Dr. Schilling

* * *

The regular monthly meeting of the Kauai County Medical Society was called to order at 7:30 P.M., October 2, 1956, at the G. N. Wilcox Memorial Hospital library by the president. Members present: Drs. Brennecke, Boyden, Cockett, Fujii, Goodhue, Kim, Kuhlmann, Schilling, and Wallis.

Changes in HMA meeting committees were made as follows: Dr. Masunaga was removed as co-chairman and appointed on the entertainment committee. Dr. Fujii was appointed chairman of the golf committee with Dr. Wallis as committee member.

Plans for formation of a woman's auxiliary were discussed. It was planned to send out letters to the doctors' wives requesting a meeting for the purpose of organizing.

Dr. Wallis, a member of the HMSA Medical Committee, reported on HMSA meetings of September 14, 1956 and September 17, 1956. Dr. Boyden explained the decision of the Honolulu County Medical Society regarding administration of P.L. 569, Medicare through the Society's Bureau of Medical Economics.

It was agreed that the County Medical Society should refer nominations for distinguished service awards to the council of HMA.

The fee schedule of Dependents' Medical Care Program as outlined in HMA letter of September 25, 1956 was unanimously accepted. It was moved and seconded to approve the California Relative Value Fee Schedule for purposes of the Dependents' Medical Care Program.

It was moved and seconded that our delegates to the coming HMA council meeting be instructed to vote for the California Relative Value Fee Schedule for the purposes of the Dependents' Medical Care Program if the consensus of other delegates favors use of this plan.

It was moved and seconded to adopt amendments to the Constitution and Bylaws as follows:

ARTICLE III

Section 1. The officers of the Society shall be elected from the active members at the regular January meeting and be installed at the same meeting.

Section 2. Nominations shall be made by the Board of Censors and shall be presented at the regular December meeting. Nominations may be made from the floor at the same meeting and at the regular January meeting.

(*Continued on page 337*)

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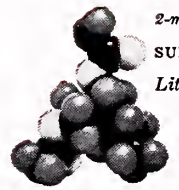
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COUNTY SOCIETY REPORTS

(*Continued from page 335*)

ARTICLE X

The Constitution and Bylaws shall be read annually before the election of officers at the regular January meeting.

The nine members present voted in favor of this motion. The changes were circularized and distributed to members in May, 1956.

* * *

The regular monthly meeting of the Kauai County Medical Society was called to order at 7:30 P.M., November 6, 1956, at the G. N. Wilcox Memorial Hospital library by the president. Members present: Drs. Brennecke, Cockett, Fujii, Goodhue, Ishii, Kim, Kuhlman, Schilling, Wade and Wallis. Guests: Dr. Ivar Larsen, Dr. John Frazer and Dr. Walter Quisenberry.

HMA delegates' report was given by Dr. Kuhlman. HMSA and minority group differences regarding the Community Group Plan and administration of PL 569 were explained.

A scientific program followed in which Dr. Ivar Larsen spoke on trauma. A film on fractures was shown. Dr. John Frazer spoke on fractures about the face. Dr. Walter Quisenberry spoke on cytology of the cervix uteri.

STANLEY SCHILLING, M.D.
Secretary-Treasurer

Maui

The monthly meeting of the Maui County Medical Society was called to order on October 23, 1956, by President Fleming at 7:30 P.M. in the Central Maui Memorial Hospital Staff Room. Members present were Doctors Tompkins, Ferkany, Ohata, Cole, Sanders, Underwood, St. Sure, Haywood, Patterson, H. Kushi, Kanda, McArthur, Tong, Izumi, Kashiwa, Wong, Burden, and Moran. Guests present were Doctors Warren White, Haff, Stevens of Molokai, and Good of Kula Sanatorium.

Dr. Fleming introduced Doctors Stevens and White. Then the meeting was turned over to Dr. White who showed the movie on fractures prepared by the American College of Surgeons. Following this he showed some slides of his own illustrating the treatment of several types of fractures which he discussed.

Following the scientific program a lengthy business meeting was held. The Board of Governors met quickly and passed on Dr. Stevens' application for membership into the Society. Then Dr. Sanders moved that we accept Dr. Stevens. Dr. Underwood seconded this motion and it was passed unanimously.

Dr. Moran presented three requests from the Woman's Auxiliary. Through the Territorial Auxiliary, they had been asked to sponsor the following and before they decided what to do they wanted the doctors' opinion:

Should the Auxiliary solicit magazine subscriptions to "Today's Health"? Dr. Sanders moved that we approve, seconded by Dr. Ferkany, and passed.

Should the women take part in the Mental Health Program? Dr. Moran moved to disapprove. Dr. Kushi seconded; passed.

Should the Auxiliary encourage contributions to the American Medical Education Foundation? It was moved that they should; seconded and passed.

Dr. Burden announced that Mr. Sheffield wanted to give all the Maui Pineapple Cannery Employees polio vaccine for $1.00 a shot—that would cover the cost of the vaccine if the Maui County Medical Society approved. Dr. Moran moved that the Society approve, seconded by Dr. Ferkany; passed.

Dr. Underwood read the following resolution:

WHEREAS, The Department of Defense has requested that the various Medical Societies select their fiscal agents on the County level for the medical care of dependents of service personnel; and

WHEREAS, The Hawaii Medical Association has usurped the rights of the various County Societies in Hawaii by naming the Medical Economics Bureau of the Honolulu County Medical Society as the fiscal agent for all the County Societies in the Territory; and

WHEREAS, The Medical Economics Bureau of the Honolulu Medical Society cannot legally be the fiscal agent for any organization since it has no charter, is not bound by the rules of the Insurance Laws of Hawaii and has no financial backing or reserve, now, therefore, be it

Resolved, That the Maui County Medical Society reserves its inherent right to select its own fiscal agent and does not feel itself bound to accept the fiscal agent selected by any other society or societies.

Dr. Cole moved that a copy of this resolution be sent to the President of the Hawaii Medical Association and to the Presidents of the various County Medical Societies. Seconded by Dr. Kushi; passed.

Dr. Moran moved that we ask a representative of Hawaii Medical Service Association and a member of the HMA Committee on Medical Practice to come to Maui to discuss current problems with the Maui County Medical Society. It was suggested that Dr. Sam Yee come representing the HMA Committee. This motion was seconded and passed.

Dr. Burden spoke on the publicity that Hawaii Medical Service Association had put in the newspapers against the Moore Report. He stated that he did not think that Hawaii Medical Service Association was right in this action and that the medical profession had been harmed by this publicity. He moved that the Maui County Medical Society censure Hawaii Medical Service Association for this action. Dr. Moran seconded this motion and it was passed with only one dissenting vote.

W. B. PATTERSON, M.D.
Acting Secretary

COUNTY MEDICAL LIBRARY

(*Continued from page 288*)

Golden, Ross, ed. *Diagnostic roentgenology.* v.3. c1956.

Meschan, Isadore *Roentgen signs in clinical diagnosis.* c1956. (gift of publisher)

Schwedel, J. B. *Clinical roentgenology of the heart.* c1946. (gift of Dr. Marie Faus)

Therapeutics

Colson, J. H. C. *Postural and relaxation training.* 1956. (gift of publisher)

Cyriax, James *Deep massage and manipulation illustrated.* 1945. (gift of Dr. Marie Faus)

Tropical Medicine

Nauck, E. G. *Lehrbuch der tropenkrankheiten.* c1956. (gift of publisher)

Urology

Dodson, A. I. *Urological surgery.* 3rd ed. c1956. (gift of publisher)

Miscellaneous

Equitable Life Assurance Society *Home health emergencies.* c1956. (gift of publisher)

Liebenson, H. A. *The doctor in personal injury cases.* c1956.



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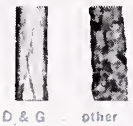
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Potts, W. J.: J. A. M. A. 157:627 (Feb. 19) 1955, p. 629.

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BOOK REVIEWS

(*Continued from page 289*)

Lehrbuch der Tropenkrankheiten.

By Prof. Dr. E. G. Nauck, Hamburg, 432 pp., illustrated, Price DM 64. (approx. $16), Georg Thieme Verlag, Stuttgart, 1956.

Since 1942, when "Ruge-Muhlens-zur Verth's-Krankheiten und Hygiene der warmen Lander" was published, there had been no textbook in the German literature on tropical diseases which contained the recent advances on the subject. Nauck's textbook has been brought up to date. It covers the subject, excels in logical approach and style and is also a manual of practical laboratory methods. The book has been written as an introduction into the subject for the students of the University of Hamburg, Germany. This may or may not be the reason that, unfortunately, the addition of a literature index has been omitted. The book can be recommended as a quick reference for the specialist and busy practitioner if he is able to read German.

H. L. MELSHEIMER, M.D.

Clinical Examinations in Neurology.

By Sections of Neurology and Section of Physiology of Mayo Clinic and Mayo Foundation, 370 pp., 76 figs., Price $7.50, W. B. Saunders Co., 1956.

This is a well written book which, in fairly simple terminology, tells the reader how to perform, evaluate, and understand the many tests and examinations now used in the study of neurological problems.

Although not going into too much detail, the anatomy, physiology and pathology being studied with many of the tests are presented. The chapters on the study of muscle, electromyography, and electroencephalography are particularly good and informative.

Mechanically the book is excellent with bold type headings, large print, clear simple diagrams, and a wonderful index.

Originally written as a guide for members of the Neurological Section of the Mayo Clinic, it is of interest to all physicians who in their practice have even the most superficial contact with neurological problems.

WILLIAM J. RICE, M.D.

Roentgen Signs in Clinical Diagnosis.

By Isadore Meschan, M.D., 1,058 pp., illustrated, Price $20.00, W. B. Saunders Co., 1956.

This book of 1,058 pages with 2,216 illustrations by a physician who is Professor and Director of the Department of Radiology at the Bowman Gray School of Medicine of Wake Forest College, Winston-Salem, North Carolina, with the assistance of R. M. F. Farrer-Meschan of Melbourne, Australia, is a very practical one to have in any office where roentgenograms are taken and interpreted. The book is more practical because it is organized by type of x-ray appearance rather than by disease. The x-ray evidence on a film can therefore be used as the starting point in the differential diagnosis of the disease entity present. The technical aspects of radiography are also covered, including positioning, dark room technique, use of contrast media, principles of fluoroscopy, etc. A single volume cannot, of course, go into sufficient detail to be of much practical value to radiologists, but it can be of assistance to most other physicians who have occasion to use roentgenograms in their practice, and is highly recommended for this purpose.

PETER J. WASHKO, M.D.

Fluid Balance Handbook for Practitioners.

By William D. Snively, Jr., M.D. and Michael J. Sweeney, M.D., 326 pp., illustrated, Price $6.75, Charles C. Thomas & Co., 1956.

This book particularly impresses the reader with its clear, concise, and simple presentations which are illustrated by visual aids and analogies. Difficult technical data and problems are clarified and the synopsis at the conclusion of each chapter emphasizes the important data. Every physician is confronted with daily problems of fluid balance, protein, and vitamin requirements and this function is often delegated to the house staff. This book is a brilliant contribution for both generalists and specialists and will help the busy doctors keep abreast with the newer concepts of fluid and mineral balance.

I heartily recommend this book as a ready reference for the hospital and office.

H. Q. PANG, M.D.

Medical Physiology.

By Philip Bard, 1,421 pp., illustrated, Price $14.00, C V. Mosby Company, 1956.

The tenth edition of Medical Physiology is a readable text designed for the student of medicine. It embodies the current concepts and the controversies. The old form of the dogmatic spoon-feeding of one "right" interpretation has been divorced as nonscientific teaching.

As a physiology text, this book is incomplete. Blood, nerves, respiration, and shock are well covered subjects and particularly practical clinically. The graphs and diagrams are lucid and pertinent, but not voluminous.

Cross indexing has followed the standard pattern with the several nomenclatures for functions referred. There are 3,042 references listed by chapter which include the old masters, contemporary masters, and original papers.

RICHARD K. C. CHANG, M.D.

Also Received

Postural and Relaxation Training in Physiotherapy and Physical Education.

By John H. C. Colson, F.C.S., M.S.R.G., M.A.O.T., 105 pp., illustrated, Price $2.50, Charles C. Thomas, 1956.

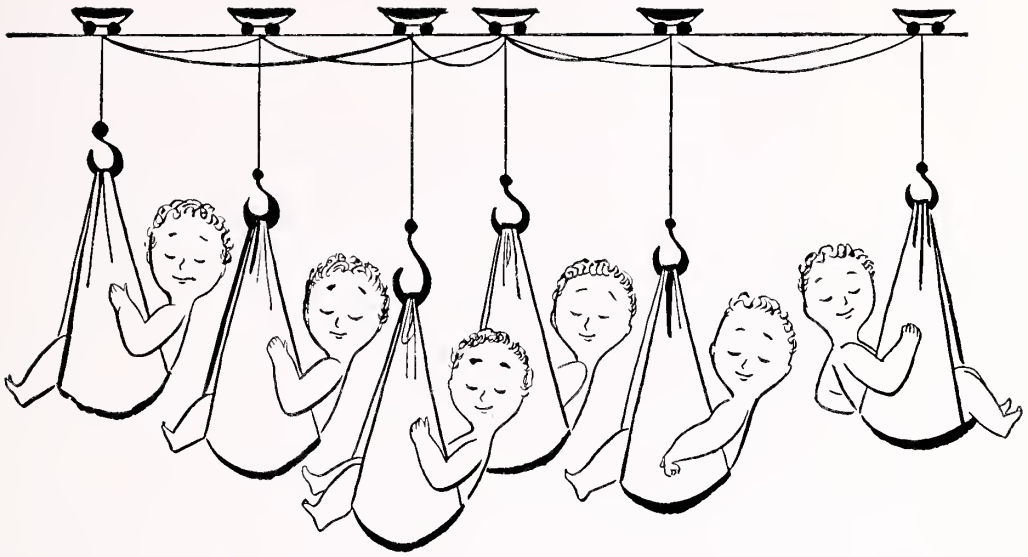
This little volume presents methods of training for correction of posture. It is well illustrated and simply written.

Pelvimetry.

By Herbert Thoms, M.S., 120 pp., illustrated, Price $5.00, Hoeber-Harper, 1956.

A practical presentation of pelvimetry which should be of interest to both specialists and physicians dealing with maternity care. The book is well illustrated and the techniques are simplified so that it is readily understandable.

(*Continued on page 344*)



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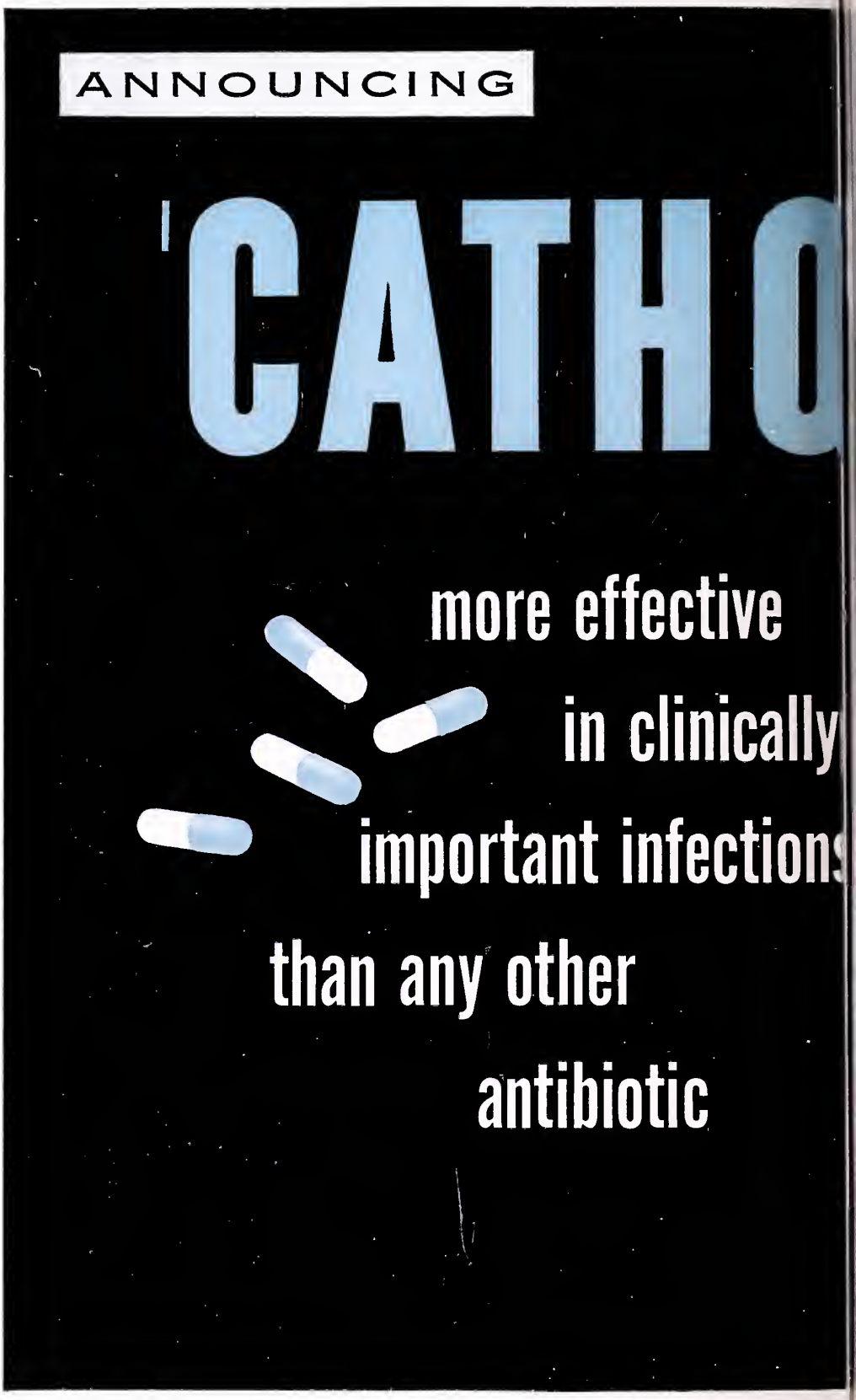
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BOOK REVIEWS

(*Continued from page 340*)

Pediatric Clinics of North America, The Child's Mouth.

Pp. 856-1,137, Figs. 1-88, November, 1956, W. B. Saunders Company.

This unusually valuable issue offers fourteen worthwhile articles in a symposium on the child's mouth and also a cumulative index to Volumes 1, 2, and 3 for 1954, 1955, and 1956. It should be in the library of every pediatrician and generalist.

The Medical Clinics of North America—Philadelphia Number—Eye, Ear, Nose, and Throat.

Pp. 1,573-1,876, Figs. 187-248, November, 1956, W. B. Saunders Company.

This volume offers eighteen articles from Philadelphia on diseases of the eye, ear, nose, and throat for the general practitioner.

The volume is also notable for a cumulative index to Volumes 38, 39, and 40, for 1954, 1955, and 1956. It is obviously well worth owning as a reference item for your library.

Neurological Nursing.

By John Marshall, M.D., 166 pp., illustrated, Price $3.75, Charles C. Thomas, 1956.

A practical book dealing with the neurological patient and the care and rehabilitation of such patients. It also presents very briefly the anatomy and physical basis of the commonly found symptoms and signs encountered particularly in the post-operative period of treatment. This book should be of interest to physicians as well as nurses dealing with such problems.

The Surgical Clinics of North America.

Nationwide Number, October 1956—Emergency Surgery of Trauma, pp. 1,171-1,438, Figs. 433-477, W. B. Saunders Company.

A symposium on emergency surgery of trauma which should be of interest to the general surgeon and physicians in industrial medicine.

Environment and the Deaf Child.

By Steven Getz, Ph.D., 173 pp., Price $3.75, Charles C. Thomas, 1956.

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*Breakey, R. S.; Holt, S. H., and Siegel, D.:
J. Michigan M. Soc. *54*: 805, 1955.

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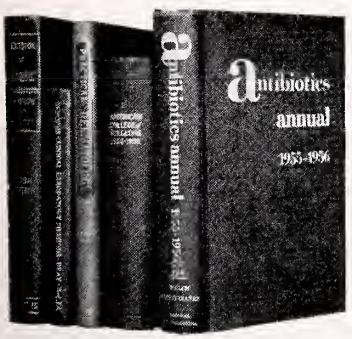
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1. Romansky, M.J., et al., Antibiotics Annual 1955-1956, p. 48,
2. Waddington, W. S., Maple, F. C., and Kirby, W. M. M., A.M.A. Archives of Internal Medicine, 1954, p. 556.

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*Ferguson, J. T.: J. Am. Geriatrics Soc. *4*:1080, 1956.

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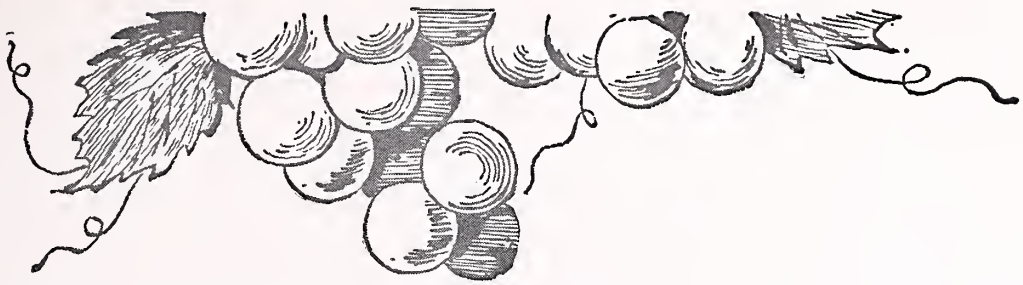
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*Uses of Wine in Medical Practice, published by Wine Advisory Board, 717 Market Street, San Francisco, California.



1. Goetzl, F.R.: Permanente Found. M. Bull. *8*:72 (April) 1950.

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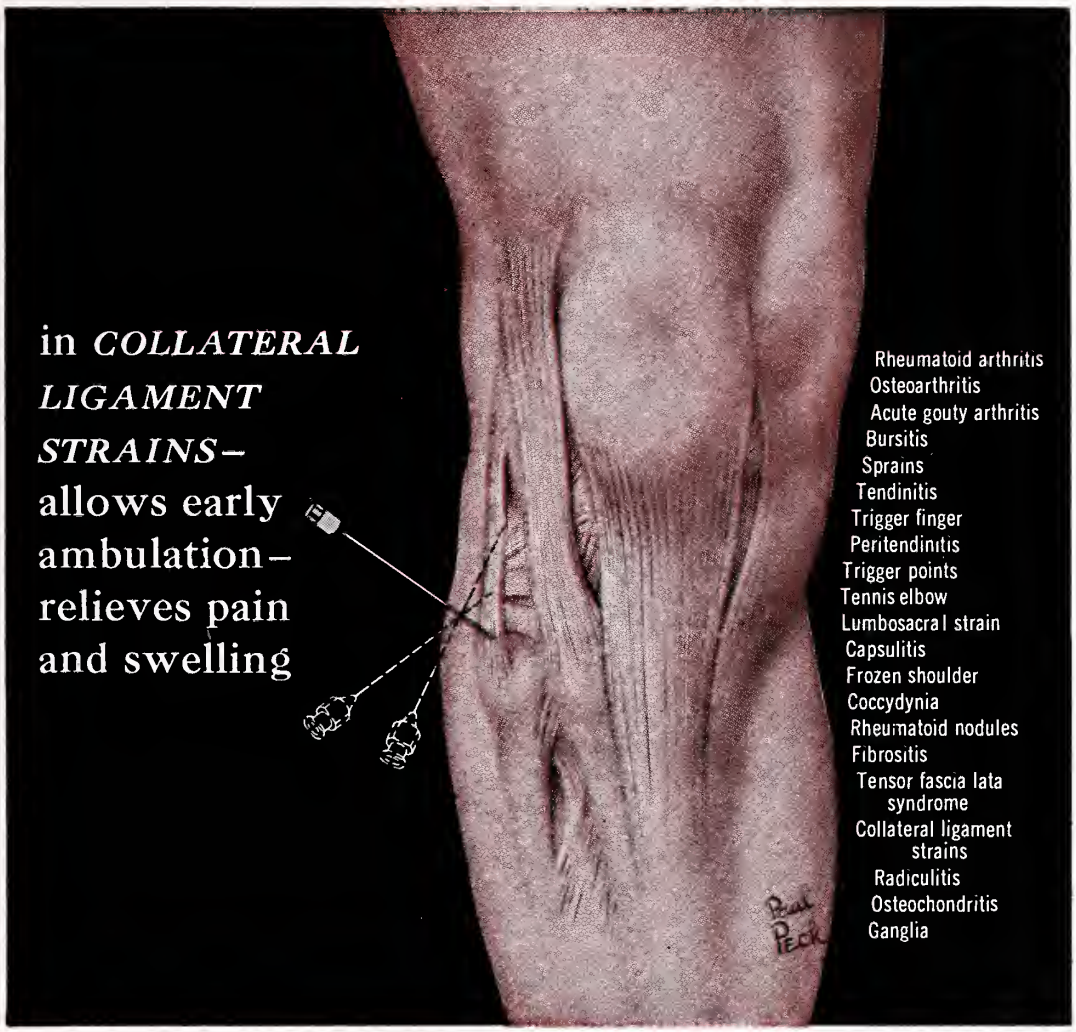
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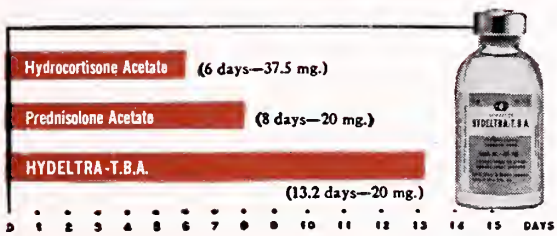
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(1) Holt, J. O. S., Jr.: Dallas Med. J. 42:497, 1956. (2) Gelvin, E. P.; McGavack, T. H., and Kenigsberg, S.: Am. J. Digest. Dis. 1:155, 1956. (3) Notenshon, A. L.: Am. Pract. & Digest Treat. 7:1456, 1956.

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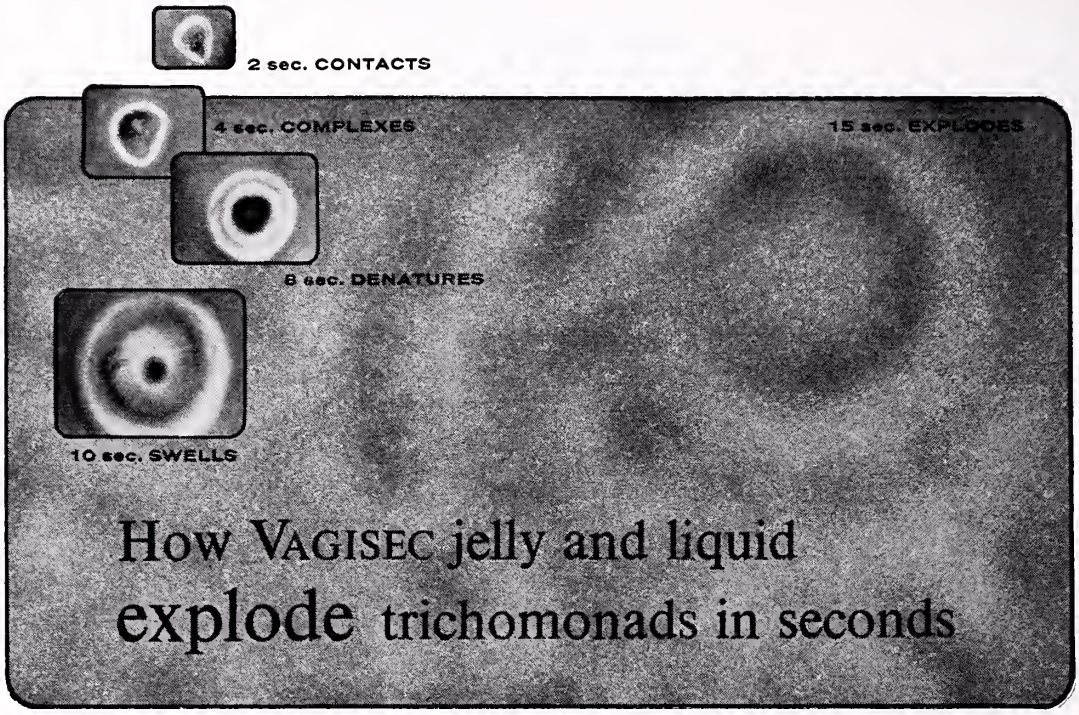
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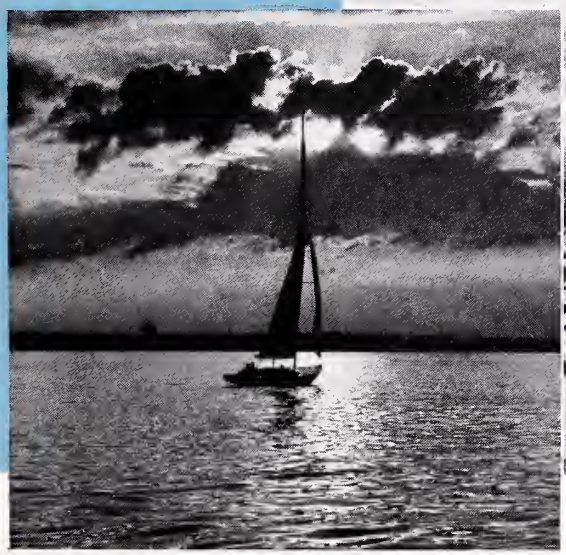
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since it is less likely to produce excessive fatigue and weakness than does reserpine."[1] Up to 80% of patients with mild labile hypertension and many with more severe forms are controlled with Rauwiloid alone.

1. Moyer, J.H.: J. Louisiana M. Soc. *108*:231 (July) 1956.

A Better Tranquilizer, too

"...relief from anxiety resulted in generally increased intellectual and psychomotor efficiency with a few exceptions."[2] Rauwiloid is outstanding for its *nonsoporific* sedative action in a long list of unrelated diseases not necessarily associated with hypertension but burdened by psychic overlay.

2. Wright, W.T., Jr., et al.: J. Kansas M. Soc. *57*:410 (July) 1956.

Dosage: Merely two 2 mg. tablets at bedtime. After full effect one tablet suffices.

Best first step when more potent drugs are needed

Rauwiloid is recognized as basal medication in all grades and types of hypertension. In combination with more potent agents it proves synergistic or potentiating, making smaller dosage effective and freer from side actions.

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In moderate to severe hypertension this single-tablet combination permits long-term therapy with dependably stable response. Each tablet contains 1 mg. Rauwiloid (alseroxylon) and 3 mg. Veriloid (alkavervir). Initial dose, 1 tablet t.i.d., p.c.

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In severe, otherwise intractable hypertension this single-tablet combination provides smoother, less erratic response to hexamethonium. Each tablet contains 1 mg. Rauwiloid and 250 mg. hexamethonium chloride dihydrate. Initial dose, ½ tablet q.i.d.

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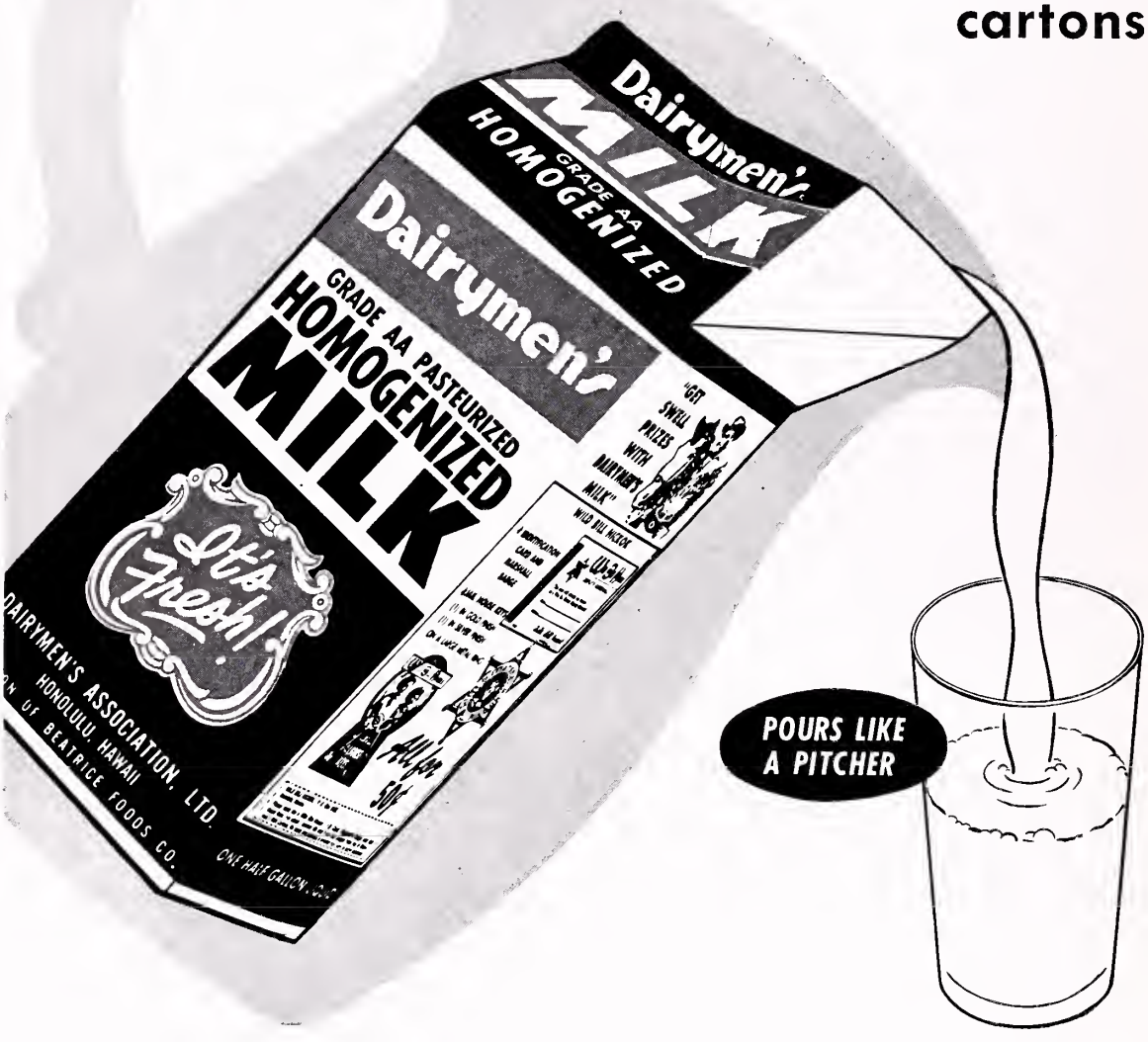
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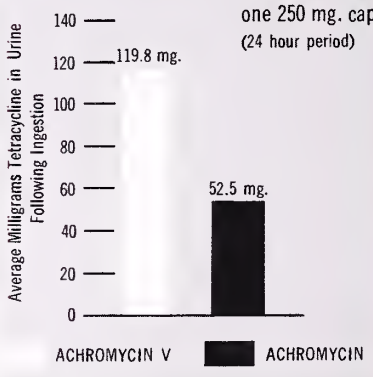
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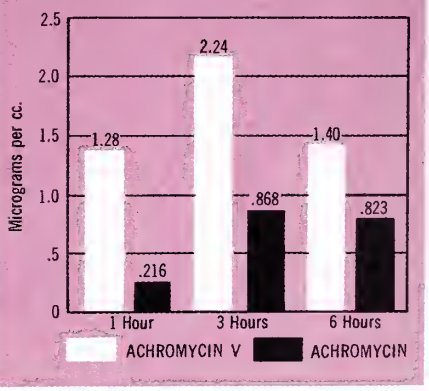
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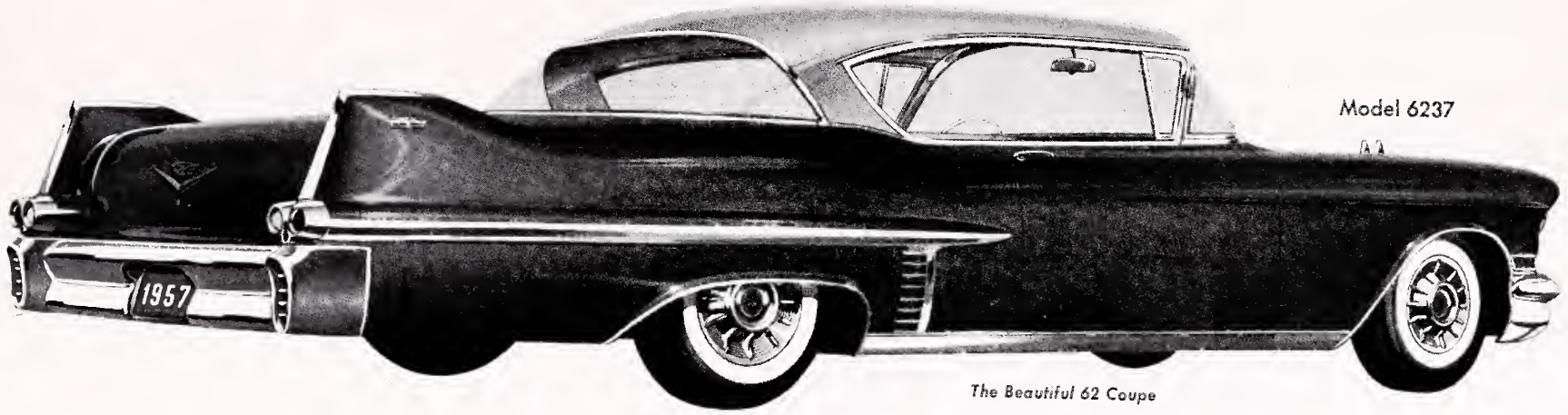


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1. The Food Exchange Lists referred to are based on material in "Meal Planning with Exchange Lists" prepared by Committees of the American Diabetes Association, Inc., and The American Dietetic Association in cooperation with the Chronic Disease Program, Public Health Service, Department of Health, Education and Welfare.



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Please send me dozen copies of the new, illustrated Knox Reducing booklet based on Food Exchanges.

Your Name and Address.

Announcing a unique new rauwolfia derivative . . .

First report on one of the most encouraging advances in psychopharmacology since the introduction of rauwolfia: a tranquilizing–antihypertensive agent which combines the potency of the rauwolfias with significantly fewer and milder side effects.

In mid-1955, Abbott Laboratories released for clinical trial a new alkaloid of *Rauwolfia canescens*. This new alkaloid, later named Harmonyl, received special attention because of the high potency and low toxicity it exhibited in extensive pharmacological testing.

Since that time, Harmonyl has been tried in conditions ranging from mild anxiety to major mental illnesses and in hypertension. Every characteristic of the drug was studied . . . evaluated . . . compared. And from the reports, one fact stands out:

- In more than two years of clinical evaluation, Harmonyl has exhibited significantly fewer and milder side effects in comparative studies with reserpine. This, while demonstrating effectiveness comparable to the most potent forms of rauwolfia.
- Most significant: Harmonyl causes less mental and physical depression. *And there are very few reports of the lethargy seen with many other rauwolfia preparations.*

This is not to suggest, of course, that side effects will not occur with Harmonyl—as with any potent therapeutic agent. But the mildness of side effects, in the few instances in which they have been reported, suggests Harmonyl as a drug of choice in conditions ranging from mild anxiety to major mental illness and in essential hypertension.

Why fewer and less severe side effects?

Some investigators suggest that the evidence of less parasympathetic effect with Harmonyl in animals might also be true in man. In chronic toxicity studies with Harmonyl this was manifested by less diarrhea, "bloody tears" and ptosis in rats than was observed with the same dosage of reserpine. Dogs also exhibited milder side effects—in particular, diarrhea. No organ toxicity or hematological change was observed with Harmonyl over a wide dosage range.

Harmonyl as a tranquilizer

While Harmonyl's safety is most impressive, clinical investigators reported other notable characteristics for this wide-range

Harmonyl*

(Deserpidine, Abbott)

tranquilizer. For instance, following an eight-month study of chronic, hospitalized mental patients, Ferguson[1] reported:

- Harmonyl benefited at least 15% more overactive patients than oral reserpine.
- Harmonyl was more potent in controlling aggression, requiring only one-half to two-thirds the dosage of reserpine.
- A number of patients experiencing side reactions on reserpine were completely relieved when changed to Harmonyl.

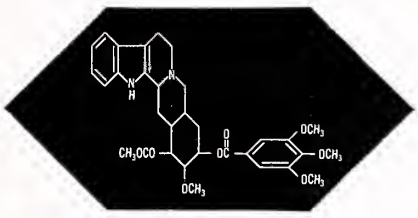
In his summary Ferguson concluded: "*The most notable impressions were the absence of side effects and relatively rapid onset of action with Harmonyl.*"

Harmonyl in hypertension

Hypertension studies show that the average reduction in blood pressure obtained with Harmonyl compares closely to that obtained with reserpine. The tranquilizing effect of the two drugs also appeared similar, except that few cases of giddiness, vertigo, sense of detached existence or disturbed sleep were observed with patients receiving Harmonyl.

Dosages In mild anxiety, as little as 0.1 mg. of Harmonyl a day may be effective. In institutionalized psychiatric patients, not less than 2 to 3 mg. a day is likely to be beneficial.

In mild essential hypertension, treatment may be started with one 0.25-mg. tablet three or four times a day. After about ten days (or sooner, depending upon response), dosage may be reduced. A maintenance dose of 0.25 mg. daily is often sufficient.



Precautions, As with other forms of rauwolfia, Harmonyl must be used cautiously in peptic ulcer and epilepsy and in patients about to undergo surgery or electroshock treatment. Despite infrequent reports involving depression, patients with a history of depressive episodes should be watched carefully.

Professional literature is available upon request.

Supplied: Harmonyl is supplied in 0.1-mg., 0.25-mg. and 1-mg. tablets.

Abbott

Reference: 1: Ferguson, J. T.: Comparison of Reserpine and Harmonyl in Psychiatric Patients: A Preliminary Report, Journal Lancet, 76:389, December, 1956. **Trademark*

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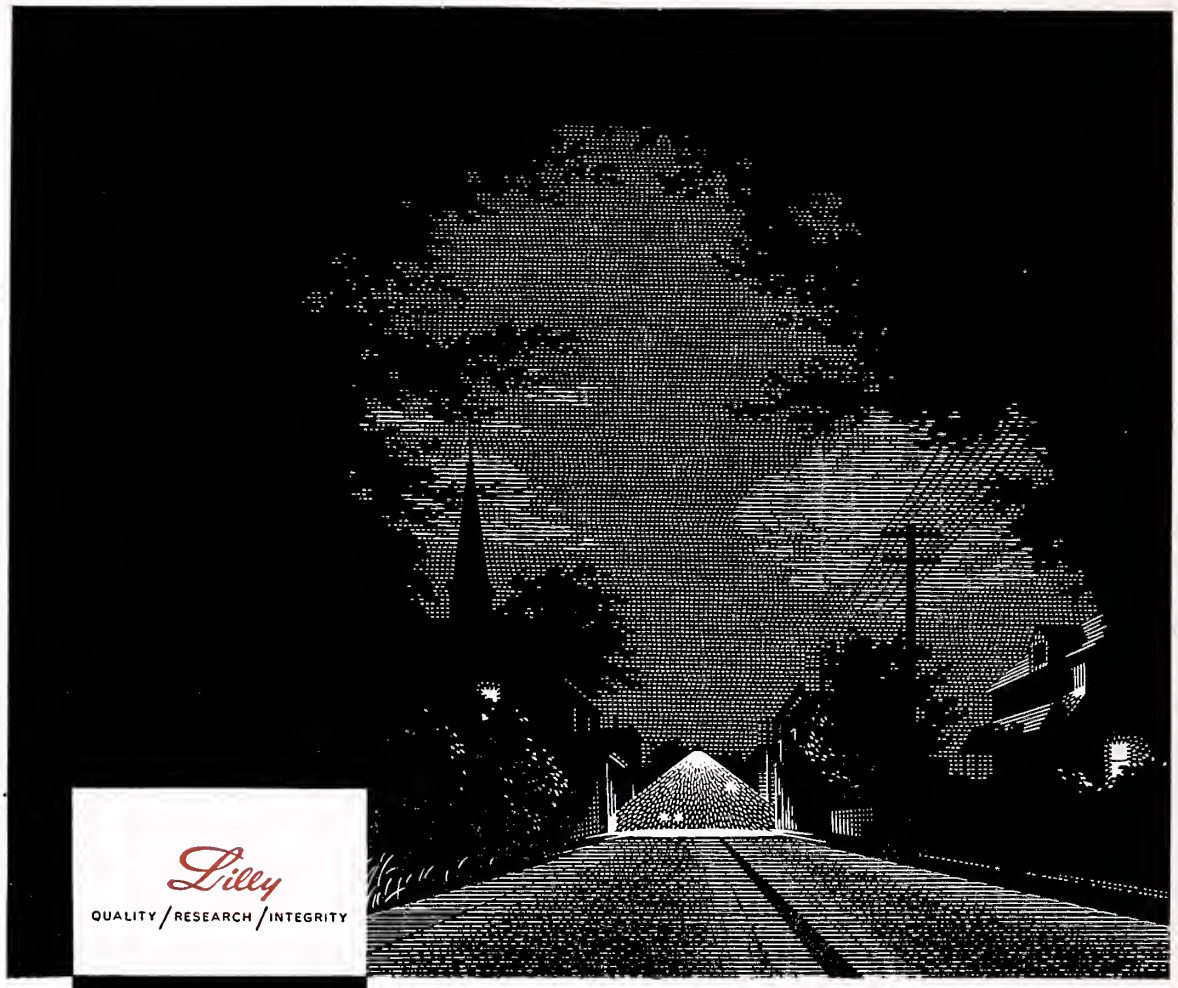
Each METRETON Tablet contains 2.5 mg. prednisone, 2 mg. chlorprophenpyridamine maleate and 75 mg. ascorbic acid. Bottles of 30 and 100.

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There are equal parts of quick-acting 'Seconal Sodium'* and moderately long-acting 'Amytal Sodium'† in each Pulvule Tuinal. Assures your obstetric patient quick, sustained amnesia; your surgical patient relief from apprehension and fear.

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THE WEALTH OF THE NATION DEPENDS UPON THE HEALTH OF ITS PEOPLE

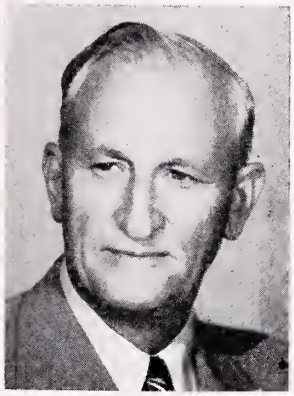
or

The Health of the People Determines the Wealth of the Nation

FORREST J. PINKERTON,* M.D., Honolulu

A peripatetic Honolulu physician tours the Far East and finds confirmation there of Disraeli's century-old dictum about the connection between personal health and national wealth.

THE PURPOSE of my visit to the Far East was tri-fold, but this report will deal with my observations as a physician concerned with the health of the people, and with my experiences as the Director General of the Pan-Pacific Surgical Association concerned with the stimulation of international good will between the Pacific countries through the medium of the medical profession.



DR. PINKERTON

From the darkest of Africa to the wastes of the Arctic Circle, the profession of medicine is perhaps the only group with a common starting point of understanding, irrespective of race, creed, color, or language differences. Since diseases, anatomical structures, and basic knowledge of such are much the same for all mankind, the physician at least starts out in his relation to other physicians with understanding and common interests. Differences of opinion may arise as the result of political, racial, and religious variances between countries, but rarely on account of their medical relationships.

We visited Fiji, New Zealand, Australia, Singapore, Thailand, Manila, Hong Kong, Formosa, and Japan and in each country conferences were held with the Ministers of Health and, through them, with their Ministers of Finance. In each country meetings and conferences were also held with the presidents and secretaries of the national surgical and medical organizations and many other specialized groups such as their orthopedic, ophthalmological, obstetrical, and gynecological societies.

A total of 33 formal discussions were held with medical groups ranging from 35 to 1500 in attendance, and many discussions were had with small dinner and luncheon groups, limited to the medical profession. In addition there were many discussions with lay groups such as the legal profession, insurance representatives, businessmen, travel agents, newspaper correspondents, radio and television representatives, and others. Most of these groups included women as well as men.

All these peoples of the Far East were intensely interested in world affairs and especially in the United States, looking upon us as the largest, strongest, and richest nation, physically unblemished by the disasters of war. They look longingly to the United States for hope of increased international trade, lower tariffs, newer methods in industry, increased transportation, and other advantages which they think we can provide. As a whole, from the point of view of the medical profession, they were proud and sensitive and in no manner apologetic or humble.

Fiji

In Fiji there is about equal division between the Indians and the Fijians in population. The Indians, being much more industrious and enterprising, center around the cities to more or less control the stores, shops, and clerical jobs. The Fijians are good natured but less industrious and seem to gravitate to the little villages along the beaches and to the small fruit farms, truck farms, and the beaches for fishing.

There is a medical school at the University which is located on the hill overlooking the city

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* Director General, Pan-Pacific Surgical Association.

of Suva, where all the shipping is centered. This school turns out about 100 new physicians a year, the majority of whom are Indians. The school does not meet the high educational standards of the medical schools of our country but their students are fairly well qualified to look after the routine medical needs of the people who are tucked away in the hills, valleys, and small coastal villages. The medical school authorities feel that the high requirements of the medical schools in the United States are so restrictive as to exclude their best students and they hope for some adjustment in our requirements that might allow a more advanced standing and recognition of a few of their best and most enterprising students.

From this it becomes crystal clear to me that it would be most disastrous to Hawaii if we made the mistake of establishing a medical school in Hawaii as has been advocated and discussed. Background of thinking, experience, and advice must be more than superficial if we in Hawaii may ever hope to maintain a medical school that would not suffer the same limitations for our graduates. Fortunately, our applicants for medical school training have a wide choice of any one of some 85 medical schools in the United States and elsewhere. All the above is true as it applies to Thailand, the Philippines, China, and Japan, though as a whole, their medical training is on a higher plane than is possible in Fiji.

Our first experience with a tropical hurricane was in Fiji, with winds as high as 120 miles an hour, and a constant downpour of rain that continued for 48 hours. We were marooned in Suva because the bridges and highways were washed away. We finally got back to Nandi via a small trimotored De Havilland plane, by following the white surf line along the shore, visibility being so bad that one could see only a hundred feet. One and a half days were lost and caused cancellation of my first and very important meeting with the medical profession of New Zealand.

New Zealand

New Zealand is possessed of the most natural beauty of any place we visited. Some of the time while we were there the weather was very rainy and gloomy. We traveled by car all the way from Auckland to Wellington and return, visiting the phenomenal and unique Glow Worm Cave at midnight (which happened only because we were so late in arriving), the countless geysers of Rotorura, the home of the Maoris, the mud baths, the hot and cold springs, the roar of the escaping steam from the many natural and man-made vents which made a good comparison to our own Yellowstone Park.

The main highways were generally excellent, but much more narrow than our own, and there was the usual repair work under way on many.

As groups and as individuals, the New Zealanders are the most courteous, kind, and hospitable people one could ever hope to meet. Unfortunately, the country as a whole is 50 years behind the times. While we were comfortable in the hotels selected for us, as a whole the hotel accommodations and other attractions for the visitor left much to be desired. New building and modernization have been kept at a standstill because of a short-sighted attitude on the part of a labor government whose controls have stifled progress in so many directions.

The health of the people is excellent and the medical care they receive is of the best. Most of the hospitals are old but well administered and the medical profession can compare favorably with the best. It is regrettable that the medical profession has been more or less singled out in the restrictive controls of the government. Dollar allowances to the profession for traveling to medical centers in other countries are so restricted and penurious as to practically forbid such educational trips. And if by chance one of them is able by one technique or another to take such a postgraduate trip, his expenses are not deductible in his income tax return. However, it is common conversation that if a jewelry merchant, for instance, elects to make a business trip, he not only has adequate dollar allowance for travel, but his expenses, I am told, are deductible in his income tax returns. Though he may be dealing in cheap, phony chip diamond jewelry that he carries in a money belt around his waist, at least his wares are tangible and can be seen, felt, weighed, and measured. Thus he is a merchant who has goods for sale, resale, and resale again with the inevitable tax added to each transaction as a government tax realization. The experts tell us that such taxes happen eight times before each jewelry item finally finds its resting place. This is not true with the physician who may bring back invaluable but intangible knowledge which adds to the health of the people, which means the wealth of the nation. All these things were thoroughly discussed with the powers that be of the government by direct conversation, the press, and the radio.

While the people of New Zealand, as groups and as individuals, were in accord with a new philosophy in the government, nothing much is being accomplished. There are two or three jobs for every available worker, and things seem to be kept that way by labor which believes, and continues to make operable, the age-old "featherbed-

ding" technique to do as little as possible in the respective job being done.

Australia

In Australia, the radical labor control is slowly becoming a thing of the past. We were in Sydney during the last election and Labor as a party lost in practically every district. One very advanced political measure in Australia is the law which requires every eligible citizen to vote. So the vote at election time is complete. The penalty for not voting is automatic, and dollar-wise convincing, as the fine is considerable.

Already Australia is becoming a booming, bustling place with many recent new buildings and many more in the building process or being planned, thanks to the influence of the New Australians. Their hospitals are, in the main, well operated, new, or modernized. Even with this progress there is an apparent shortage of beds in most cities but this is gradually being corrected. The shortage of beds and surgical facilities is due more to lack of nursing and other trained personnel—such individuals are awfully underpaid. The old nursing home technique for the care of the chronically ill and the convalescent patient continues as in the past and for the present, they are necessary until better methods are developed. The nursing homes are practically all privately owned, subsidized in part by the government, whereas the hospitals are government built and essentially government operated.

In contrast to our expensive and archaic city and county indigent medical care program, physicians are not allowed to ride the ambulances, the only attendant being a well trained first-aid man. There are no sirens on the ambulances, only an innocuous bell which may be used for right of way in crowded traffic areas; the driver of the ambulance personally suffers the same penalty for speeding as does any other citizen caught violating the traffic laws, the only exception being if he has a police escort to clear the way in case of a mass disaster. In all the countries we visited, there was no exception to this rule. Even in Hong Kong, traffic of ambulances is controlled and doctors are not allowed on the ambulances; "only for fun," they laughingly replied to my questions.

The Australians feel the tariff restrictions of the United States against the use of their wool, dairy products, and meat. This may be, in some measure, a reason for their retaliatory restrictions against too many dollar allowances for travel to the United States. In this respect, however, they are much more liberal than New Zealand but they, likewise, do not allow physicians tax deductions for travel to mainland meetings, conferences, and postgraduate expenses.

The "New" Australians from other countries are encouraged by the Australian government to bring in new people to settle and colonize the vast expanses of a virgin country as large as the United States. These new Australians—Czechoslovakians, Greeks, Italians *et al.*—are workers who are not afraid to do an honest day's work for a day's wage, and since there are so many jobs open as a result of Labor's decades of featherbedding, there is plenty of work available for those who want to work. The Australian observes the beneficial changes that are taking place. And as is to be expected, labor leaders are seeking ways and means to prevent anyone from doing a full day's work for a day's pay; the people are at their best when on a holiday and they take days off at the slightest excuse.

Our contact with the medical profession and the people of the universities and the government was most cordial. Their cordiality and kindnesses could not be surpassed. Sydney men of the profession are strongly advocating a meeting of the Pan-Pacific Surgical Association as soon as possible in their country. In this they have the strong support of their Chambers of Commerce, their government, and every other interested group. When we are ready for such a meeting, there is no doubt in my mind that they can handle it with ease.

We visited Melbourne and Adelaide for several days each. Melbourne is a fabulous city, very much like Paris, with its wide boulevards and general layout. The week we were there was "Moomba Week," or "Let's get together and have fun" week. During the famous, gay, festival week everyone was in a holiday mood, the annual racing event for the occasion was on, every large and small craft in the harbor was decorated from stem to stern, bands were playing everywhere, and the streets were decorated with colored lights, banners, etc.

Hospitals are modern and well administered, but short of nursing and attendant care. Bed shortage is acute here, as it is in Sydney, and in both places bed assignments are made from a central pooling place where all beds are controlled by a government agency and the medical profession is definitely limited and controlled not only in the quantity prescribed but also in the kind of medicine ordered. They have put into restrictive operation a regulation to control certain antibiotic drugs which, as our own doctors have learned, become ineffectual in some diseases and in certain individuals if used too often or too long. They recognize this and reserve certain of the most expensive and valuable drugs for the real emergency or serious cases. In obstetrics they have found a certain strain

of staphylococcus which is resistant to all known antibiotics, due in their experience to overuse and abuse of antibiotics. In this regard also we can learn much from our colleagues down under.

Our stay in Adelaide was enjoyable indeed. Here we were received with the same perfect aloha as everywhere else. The city is a beautiful old place with its wide streets, beautiful gardens, and homey atmosphere. The hospitals were old but were run with the very best of skill and ability which was everywhere evident. At the Old Adelaide Hospital they were in the process of building a new wing which was almost complete after nearly five years of brick by brick feather-bedding. But the medical profession is alert and is having installed a five million volt deep x-ray therapy unit.

We were there during the sheep shearer's strike. That being the time for sheep shearing, the "Commies" inspired a strike because the Wool Association invoked the clause in the primary contract calling for less pay in proportion to the drop in price of wool. This year the government stepped in and ignored the strikers and placed militia protection around each plantation and group of workers to allow the operation to go on, and promised protection to the station owners from now on out. Wool being their basic industry, the government realized that the very life of the country depended on wool production and, unlike our government officials, they took over in the national interest.

Our schedule took us back to Sydney via Canberra where we were scheduled for luncheon with the Ministers of Health and Finance, and others. Unfortunately, the weather was very heavy and visibility over Canberra was so poor that after circling for an hour we had to go on to Sydney. Here we remained for four more days. Constant rain and excessive sultry heat continued throughout our stay. Interviews by the press and radio kept us busy and when we left Sydney for Singapore, we were genuinely sorry to leave, but our first departure was not for long because we developed engine trouble after two hours and had to return to Sydney to spend that night, getting off the next day at noon.

Singapore

This loss of one more day made us two and a half days behind our schedule, so our stay in Singapore was shortened in order that we could get back on a schedule that was very tight from the start. Because of this schedule interruption, no time was available in Singapore to follow through on the original plans. I was able, however, to discuss medical affairs with several key individuals one morning.

Seventy-seven per cent of the population in Singapore are Red Chinese who insist upon independence from England; the remaining 23% are Malayans and others who do not want independence. We were in Singapore at the time of the Communist uprising which ended in a riot near the airport when several people, including one policeman and one soldier, were killed and 150 others were seriously injured. We found ourselves in the midst of this screaming mob of Chinese, with their banners, big trucks, and oblivious indifference to the rights of all others. The people of Singapore resent bitterly their cruel and inhumane treatment at the hands of the Japanese when they took over the city in World War II.

Thailand

Leaving Singapore in the early morning, we headed for Bangkok, Thailand. As usual, our arrival at this fabulous city was heralded by a large reception committee headed by the Minister of Health, the Chief of the Medical Department of the Air Force, the administrators of two of the largest hospitals, the President of the Surgical Association, and others. After the usual picture taking, greetings, and press interviews we were taken by private car to our hotel in the city, where we were allowed to rest the remainder of the day.

Early the next morning, I was partially back on schedule and making visits to hospitals and medical points of interest with a large luncheon attended by the principal figures in Public Health, hospital and surgical practitioners, including the dean of the most important university medical college. This procedure was followed daily throughout our stay in Thailand.

Many of the hospitals are either new or very recently modernized and present a perfect system of administration. They have wide-spread, sheltered walkway spaces connecting the huge wards, where the square feet space per bed is, as a whole, much larger than in our country.

The physicians with whom I had closest contact were men of the highest calibre and training. Their progress in the surgical world is nothing less than phenomenal and they take second place to none in the world in the sphere of ability and training. They were proud of their statistics and records and have made the positive observation that cancer of the uterus ranked first in the incidence of cancer, then malignancy of the breast, and then cancer of the oro-pharynx, in that order. Most of these cases were far advanced before they came to the attention of the medical profession. It was tragic to see so many in such advanced hopeless condition due to the interference of the Buddhist priests who, even though they know better, attempt to treat these people by prayer,

mystic medicine, and other hocus-pocus, and keep them under their religious therapy until they are not only penniless, but long since past any hope of medical or surgical cure. These priests exercise almost total control over these people in their medical treatment and care for every kind of illness.

In all parts of Thailand, there are countless numbers of "wats" or religious temples. They are fabulous structures, with 24 carat gold-leaf covering the outside of the roofs and walls, and the countless Buddhist monuments or statues are frequently encrusted with precious and semi-precious jewels of every description. Since their independence, the upkeep of such structures, which is very expensive, depends on volunteer contributions by the public at large and the few visitors that come to see these priceless structures. It is required by law that every male citizen must give a minimum of two full years after his eighteenth birthday for training as Junior Priests of the Buddhist religion, and so in every one of these temples one sees countless young men swathed in golden yellow robes serving the Buddhist religion. From this it can be seen what a tremendous hold the national religion has over every Thailander. The economics of Thailand is sorely tried to keep up these pretentious edifices.

There are many typhoid cases right in the large wards, unsegregated from other patients. The profession seems to have no fear of cross infection even though there are flies everywhere as well as other apparently easy means of disease spread.

All hospitals have their own schools of nursing and graduate very large classes of nurses. The trim little Thailander nurses dressed up in their natty uniforms make a pretty picture indeed. To the last in the line, these little nurses are beautiful to look upon. At graduation they get $15.00 (equivalent) a month, unless by chance they are promoted to chief nurse of a large ward of one or two hundred patients when they are paid a maximum of $40.00 per month. The house staff of residents and interns gets nothing. When they finally acquire their M.D. degrees, and work full time as assistants, they get $50.00 a month. Later on, as assistant professors, the salary is gradually increased until they are full-time heads of a department when they get a maximum of $150.00 for genuine *full*-time employment. If they finally get professional rank, their pay is increased proportionately depending on the importance of the department they are designated to head in that specific hospital.

A new surgical wing is now being completed in one of the largest hospitals. It is a show place of marble and modernity with many many operating rooms, each of such huge size as to make our best and largest operating rooms seem small indeed. Their equipment was the most modern and up to date and their x-ray and pathological departments were elaborately large and manned by highly qualified trained specialists.

This being a poor country, the "outpatient" service was naturally very large, and one hospital has an outpatient service of more than 200,000 individual patients a year. It is hard to conceive how well these 700 bed hospitals were operated, especially since all hospitals are most complex to operate, far more so than any business of proportionate size.

All hospitals here have their own individual blood banks with skilled technicians, many of whom are trained in the United States and Britain. Their equipment is fair but not so modern as our own and I have promised to send them some expendable sets of donor and recipient equipment. They use blood freely, but not as liberally as we do in our country. They too have learned that every twenty-fifth dose of blood is the one definite procedure that saves a life.

They are a happy, courteous, kindly, hospitable people and we learned many lessons from them during our short stay and we enjoyed their routine best. Travel restrictions and dollar control of Thailand physicians are much more liberal than in Australia and New Zealand.

From Bangkok we flew direct to Hong Kong, by-passing Manila. We were glad to be in Old Hong Kong again. By this time we were both so tired that we were happy indeed to hole up in the Peninsula Hotel for a few days of rest and relaxation. We soon got our bearings, did a bit of shopping, and visited our old friends.

Philippines

Four days later we turned back on our course and flew to Manila where we spent four of our busiest days. Mrs. Pinkerton had been in Manila with her family in the military service when she was but eight years old. She saw many changes from old Manila as she remembered it, and so did I notice the great changes that had taken place even since I was there three years ago.

Manila Bay is now cleaned up of all the hundreds of half sunken hulks of Japanese war craft of World War II. It will be recalled that our naval aircraft caught the Japanese fleet off guard and bottled up in Manila Bay, and completely annihilated the entire fleet.

The Filipinos have done a superior job in cleaning up the terrible destruction of World War II. The miles and acres of rubble of even three years ago has been almost completely removed and modern new buildings have sprung up. Unfor-

tunately the hospitals and outpatient services are in great need of modernization and supplies. There seemed to be plenty of money, government and private, to rebuild the city but the improvement in hospitals and similar facilities is noticeably lacking in proportionate consideration. In a conversation with the Philippine Minister of Health and the Mayor of Manila it was pointed out that the many new and inspiring church edifices among countless old structures seemed out of proportion to any material improvements in hospital areas. It was explained that Manila was undergoing a great spiritual upsurge—they felt that the spiritual things should come first and that the hospitals, outpatient and other facilities, would be taken care of eventually. It seemed to me that there was a total unbalance between the spiritual and the physical.

There was much in the public press that was critical of the United States because while they had their independence from the United States, it seemed that with that independence they felt they had been forgotten about and treated like other nations in the way of restricted trade, restrictive tariffs, etc. They didn't want to be placed in the category of other nations to receive surpluses if and when they existed in the United States, at a marked up price, for more than they were worth as surplus. Because of limited trade and high tariffs, they felt it necessary to restrict dollar allowance to their people for world travel and here again we saw the restriction on the tax allowance for the medical profession in school and postgraduate study in other countries.

There are five medical schools in Manila, only one of which turns out physicians with creditable training, this being the University of the Philippines. The effect of the graduation of all those poorly-trained physicians upon the quality of medical care was already beginning to be felt in the city. Such wholesale manufacture of physicians was dragging down the high standards of good medical practice.

We were royally received in Manila and treated as royal guests while we were there. The cordiality and hospitality could not be surpassed. No time was lost in exploring possibilities or in getting to our objectives. We were taken to all places of interest including the countryside. I spoke before two very interested and interesting audiences on medical subjects, on international relations, and the Pan-Pacific Surgical Association. Just as we were royally received, so we were also given a royal aloha at departure time.

Hong Kong

Our return to Hong Kong via Formosa was uneventful. Both Formosa and Okinawa were exactly as I remembered them three years ago. On our second visit I attended two meetings, one luncheon and one dinner, in Hong Kong. Those in attendance were in the majority Chinese, with a few Americans and several British physicians. The interest there was very keen in the Pan-Pacific Surgical Association and the topics of conversation were otherwise in the main, international in scope and nature.

Some considerable concern was felt regarding the communistic influence and control in Hong Kong. It is common to hear the expression of fear for the future of Hong Kong because in some high circles it is felt that sooner or later the province will fall into communistic hands. It seems to be but a matter of time. As matters now stand, it would seem that there would be no point in the Reds taking it over since it presently functions as an outlet for Red China goods. It appears to hinge around when and if the United States and the United Nations recognize Red China in the United Nations. If that time comes then they, the Reds, could easily step in and take over Hong Kong.

High British authorities say that although the British Army has a large force of men there, with plenty of fighting craft in and out of the harbor, they are building no elaborate or permanent structures to house their forces and the necessary noncombatant units. The most pretentious modern building in the whole city is owned by the Red Chinese and houses the Bank of China, which is also owned, controlled, and operated by Red China.

So far as I know, the only country that requires a certificate of origin for purchases of Hong Kong goods is the United States. Hong Kong is a free port, no taxes are levied against any goods coming in, so it is possible to buy the very best of everything the world has to offer in the way of clothing, jewelry, and photographic equipment at one-third of its price in the United States or anywhere else.

A short journey to the "River of No Return" gives one a chilly spine. Just across the river and the high fence is Red China, where all people wear the same clothes, eat the same food, and live in comparable housing no matter what their individual ability, industry, or desires may be. These people are very unhappy and no wonder they commit suicide by trying to swim the river to freedom on the darkest of nights. When they are caught they are shot. The living conditions of the successful refugees in the freedom of Hong Kong are horrible. Hong Kong is not equipped to feed, house, and care for the thousands and thousands of refugees that have gained freedom. While

Hong Kong authorities are building countless housing units, they cannot keep up with the constant influx of new arrivals.

It is not generally known in this country that the airport in Hong Kong is considerably less in size and length of landing strips, than normal; consequently, no plane is allowed to come in or take off after 6:00 P.M. or thereabouts, or before daylight. So we took off early in the morning for Tokyo in a DC-4, the old C-54 of Air Force fame. We had fair visibility until we had been in the air for an hour or so, landing at Taiwan, Formosa, for a brief service stop. Passing over Formosa reminded me of my experience there three years ago when I had the opportunity to see it from several angles; it was in the flight from Formosa to Clark Field that first one and then another engine failed after we had passed the point of no return, an experience which is best forgotten. Passing over Okinawa on this last trip was not part of the scheduled route since it is thirty minutes off the direct course, but again on this flight some engine trouble caused the change in course with the probability that we would have to land on Okinawa in case the failing engine caused a forced unscheduled landing. Fortunately adjustments were made that righted the engine trouble, so we did not land. However, again flying low, I was able to get a good view of the place that I had known so well three short years ago.

Japan

Our arrival in the evening at Tokyo was without incident, except we were behind schedule. As was the case in all our landing experiences in the various countries, we were accorded a fine reception. Several surgeons and their wives were there to greet us. It was pleasant indeed to be expected and to be met by prominent ladies and gentlemen of the profession who accompanied us to our hotel rooms where we were left alone to rest up from an all day flight.

Early the next morning I was taken to the 60th Annual Meeting of the Japanese Ophthalmological Association to which I had been invited to give a scientific paper and to discuss also the aims and ideals of the Pan-Pacific Surgical Association. This was a large meeting with a thousand or more ophthalmologists in attendance from all parts of Japan. The reception was pleasant and my talks were well received. It was very cold in the huge auditorium and most of those in attendance wore heavy clothes and overcoats. The meeting over, there was time enough left to do a bit of shopping and browsing around to revisit the familiar places that I remembered so well.

That afternoon I had a small meeting with Japanese members of the Pan-Pacific Surgical Association and other surgeons who had in the past attended Pan-Pacific meetings in Honolulu. Much interest was evidenced by everyone with whom I conversed and I am sure there will be a goodly representation from all the countries we visited if ways and means can be found to overcome the dollar restrictions evident everywhere.

I was invited to attend the three day scientific seminar being held in Tokyo by the United States military medical profession, but could not accept because of the already crowded pre-arranged schedule. The next morning I was called for by car to go to Yokohama to speak before the annual meeting of the Japanese Orthopedic Association. This mission was completed shortly after noon and I hastened to a luncheon meeting at the New Grand Hotel.

Again, that evening, we were royally entertained by a large group of surgeons at a famous Japanese teahouse, where I again discussed the affairs of the Pan-Pacific Surgical Association. Late that night we left for Kyoto by night sleeper train for the "classic" city, the City of Art of Japan. The Cherry Blossom Festival was in full swing. The famous cherry blossoms were not much in evidence in Tokyo, but as we journeyed three hundred miles westward, the weather became noticeably warmer. Our three days in Kyoto were memorable ones. The color of the city was in full splendor and everyone was out in his holiday best. There were cherry blossoms everywhere, on every lamp post, fence, doorway, and tree. Through our friends we were fortunately able to obtain admission to the Cherry Blossom Festival Dance of the famous Geisha Girls' Association, which is given only once a year. The color, the stage effects, the music, and the dancing made the performance a never-to-be-forgotten affair. When some sixty pretty geisha girls all in continuously changing, beautifully colored gowns performed and paraded before you for two hours, accompanied by as many musicians, it can be understood how impressed we were.

All of the time in Kyoto and Nara, we were accompanied by an English speaking guide and a chauffeur with private car. Thus we lost no time in getting from place to place and our guide, a professor of language at Kyoto University on vacation, gave us a constant accurate running account of history, points of interest, and places to see. We saw the main shrines, temples, castles, and statues with a good look at the city and its environs. The lacquer, porcelain, tea, silk, and dyeing industries were all seen and explored. The Gold Temple, the Buddhas, the big bells were all presented to us with ease and dispatch. The 700 ton bronze

Buddha, the 70 ton bronze bell, the parks, the resorts and the holiday mobs were all presented to us in rapid order.

During this festival season, all schools in Japan are on a two-week holiday. All students from kindergarten to college seniors were on holiday, and it seemed to us that they were all visiting the points of interest just as we were, except we were privately conducted and were allowed to visit many interesting and off-limits spots not accessible to large crowds. All students, boys and girls, were in their regular uniforms, standard for all students, but each group had its own distinctive insignia which identified them to those who could read the insignia. The same thousands and thousands of students were ever present at every point we visited, some coming from great distances by train and bus.

The weather was perfect all the time we were on the only holiday we had on the whole trip, this short excursion to Kyoto, Nara, and Atami. When we boarded a day train in Kyoto to return to Yokohama, it began to rain and as we went farther east, it turned to snow. At Nikko the snow was very heavy and the weather was very cold but in Tokyo it cleared up somewhat and we were able to see more of the city and to visit the famous tea house of Chinzanso. This famous garden has existed since the Meiji period more than 1,100 years ago; in 1945 it was partially destroyed by fire, later to be completely restored by donations from well-known people in high financial circles. Restoration of this famous place was completed in 1952.

Several medical, surgical, and specialty clinics were visited as well as hospitals. Medical service to the hordes of residents of Tokyo is apparently going along in a manner somewhat satisfactory to the people. But the material, supplies, and essential equipment necessary to good service were sadly lacking. The medical profession of Japan with their limited facilities are doing a very creditable job in their care of the sick, their industry and ingenuity placing them in excellent position to do their colossal jobs well.

Tokyo is terribly overcrowded with the great influx of rural people, mostly of the younger age group, students of one variety or another. Considering that there are nearly one hundred universities and colleges of various kinds, it is understandable that so many students migrate to Tokyo.

The whole empire of Japan is an area approximately the size of California. The population of the empire numbers about one hundred million souls, ten million of whom live in Tokyo. Of these ten million people, about one third are without gainful occupation, since there are no jobs to be had. Yet the city is clean, busy, orderly, and well regulated. Statistics show that the crime and delinquency rate is favorable indeed as compared to our own small community or most other overcrowded American cities. The birth control or "space control" meeting which was held in Tokyo last fall certainly did not fall on barren ground. I am told by good authority that the day of large families in Japan is already disappearing but, unfortunately, that time is late in arriving to relieve the present emergency situation.

Officially, Japan is begging the United Nations to make available to them islands in the Pacific upon which they may locate and colonize with their overcrowded millions. They are an industrious race and are seeking an opportunity to work. With this tremendous population, overcrowding, and economic distress, it is clear to see why these people are worried about communism, since such conditions are the best breeding media in the creation of communism or any "ism" that will relieve their situation.

Japan wants from the United States more trade and an opportunity to supply our country with more of their goods. They bitterly resented the legislative action of North Carolina in publicizing dealers who sell Japanese goods, which they interpret to be nothing less than a Japanese boycott. Be that as it may, the observations made above come from the highest authority as reported by high officials and as reported editorially in the Japanese newspapers.

Conclusion

In conclusion, our experiences in the nine countries we visited left us with the impression that the Far Eastern Pacific countries can contribute much to the world in the way of culture, art, industry, and inventiveness. Medically speaking, every center of contact brought out the fact that the profession is of high standing in training, integrity, and medical practice. The health of these crowded nations is good and great credit must go to the profession in the healing arts. We have always heard so much of the bad water, etc., but at no place visited did we find that to be true, as all water is chlorinated, clean, and plentiful except in Hong Kong where the water supply was limited to use only during the hours between 5:30 and 8:00 P.M. each day.

Our hosts in every one of the nine countries were gracious and hospitable, our experiences ever rich in enjoyment and accomplishment. We learned that our Pacific neighbors were the kind of folks we could live with, work with, and play with.

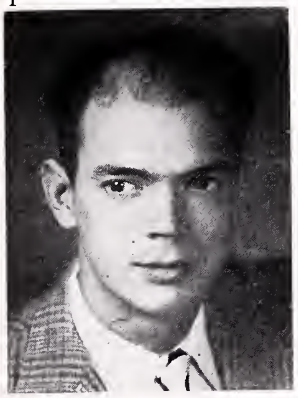
Alexander Young Building.

GASTRODUODENOSTOMY

J. W. CHERRY, M.D., Honolulu

The Billroth I gastroduodenostomy has fallen into undeserved disrepute. Its simplicity and relative freedom from complications warrant its continuing use in selected cases of gastric ulcer.

ADEQUATE GASTRIC resection with or without vagotomy is generally accepted as the procedure of choice in treating those ulcerating lesions of the stomach which require surgical intervention. Restoration of gastrointestinal continuity is by way of gastroduodenostomy or gastrojejunostomy. These operations are based upon procedures described in 1881 and 1885, respectively, by Billroth. There are numerous modifications of these, but all gastroduodenostomies may be classified as Billroth I and gastrojejunostomies as Billroth II anastomoses.[1] Contrary to popular opinion, the second operation was not devised to correct the shortcomings of the Billroth I but was originally intended as a two-stage procedure for those patients whose conditions did not permit gastrectomy in one stage.



DR. CHERRY

The Billroth I procedure fell into disrepute because of complications related to technique; namely, leakage of the anastomosis at the critical angle, and gastric retention. The disparity in size of the stomach and duodenum was largely responsible and many of the early modifications of Billroth II were end-to-side anastomoses of the full width of the gastric lumen. These objections above are no more applicable to Billroth I procedures than to Billroth II and are directly related to the care exercised in constructing the anastomosis rather than to which one is utilized.

Although gastric resection has come to be accepted as the best procedure available in the surgical treatment of peptic ulcers and the mortality rates have fallen to fully acceptable levels, many surgeons as well as internists are well aware of its disadvantages. Removal of a large amount of the gastric reservoir has been attended, as is well known, by an appreciably high incidence of unpleasant side effects such as failure to maintain weight, dumping syndrome, so-called gastric cripples, diarrheas, and occasionally anemias, in addition to numerous minor discomforts. Most American surgeons have preferred to use a modification of the Billroth II reconstruction during the years that gastrectomy has been utilized here. However, the above-mentioned disadvantages have caused many to seek a procedure which alters the physiology of the gastroduodenal complex to a lesser extent.

Polya, whose name is attached to the Billroth II procedure, which has been favored by many, stated in 1940 that he preferred to use the Billroth I reconstruction whenever possible because it was more physiologic.

In the past eight years, surgical literature in American journals has contained numerous articles concerning experiences with the Billroth I procedure and with experimental surgery investigating the relative merits of the two procedures. Data related to some 3,000 Billroth I procedures have been accumulated and analyzed.

Physiologic Advantages

The ideal surgical procedure corrects the pathology with minimum alteration of normal physiologic mechanisms. In dealing with the complex processes involved in food digestion in the gastroduodenal area, it is particularly desirable to adhere to this principle as closely as is feasible. It is well known that the flow of bile and pancreatic enzymes is stimulated by the entrance of food into the duodenum. It is less well known that the presence of hydrochloric acid in the duodenum inhibits secretion of acid by the stomach, and that the introduction of alkali into the stomach (such as occurs constantly with isoperistaltic gastrojejunostomies) actually stimulates acid secretion by the organ.[2]

Experimental work by Wallaeger related part of the disturbed gastrointestinal function following subtotal gastric resection to the loss of fat and nitrogen in the feces. He further showed that patients with Billroth I lost significantly less than

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[1] Moore, H. G., Jr.; Schlosser, R. J.; Stevenson, J. K.; Harkins, H. N.; and Olson, H. H.: Clinical Analysis of Billroth I and Billroth II Subtotal Gastric Resections, Arch. Surg. 67:4 (July) 1953.

[2] Moore, H. G. and Harkins, H. N.: A Critical Evaluation of the Billroth I Gastric Resection, Surgery 32:408 (Aug.) 1952.

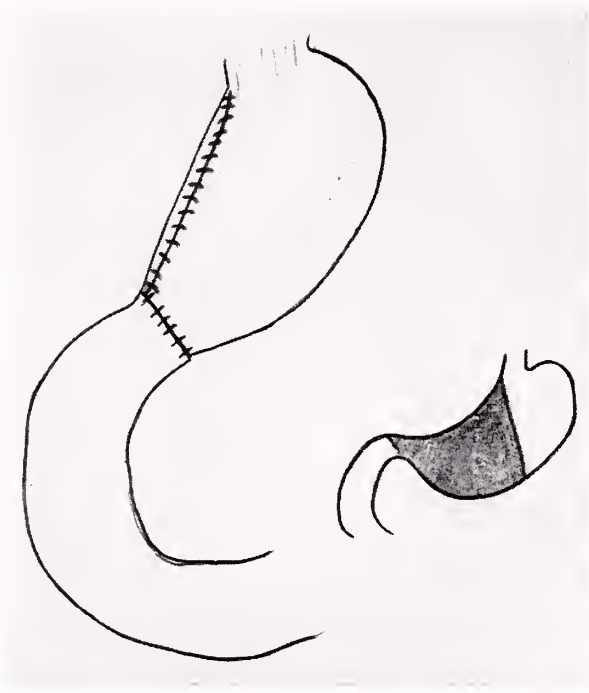


FIG. 1.—Billroth I subtotal gastrectomy (gastroduodenostomy). Smaller figure indicates amount of stomach resected.

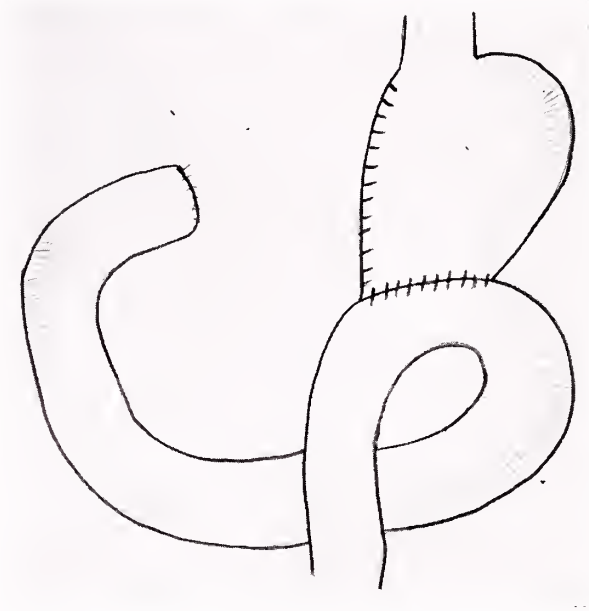


FIG. 2.—Billroth II subtotal gastrectomy (gastrojejunostomy).

those with Billroth II, and this work was confirmed by Cole and associates. Further experiments by Dragstedt, *et al.*, and independently by Moore, *et al.*, demonstrated that marginal ulceration occurred less than one-fourth as often with Billroth I as with Billroth II in antral hyperfunction resulting from transposition of the antrum into the colon. The latter authors were able to kill 100 per cent of their experimental animals with Billroth II anastomoses by injecting histamine, causing marginal ulcers which perforated or bled. In a similar group of animals with gastroduodenostomy, only a single animal succumbed to identical dosages of histamine even when carried on over much longer periods of time.

In addition to the physiologic advantages of the Billroth I operation over the Billroth II, Clagett and Waugh[3] list certain technical advantages: (1) it is faster and easier; (2) blowout of the duodenal stump is avoided; (3) the entire operation is carried out in the supramesocolic compartment of the abdomen with minimal or no disturbance of the colon, mesocolon or small bowel; and (4) kinking at the stoma is avoided.

Criticisms by opponents to the Billroth I procedure are (1) inadequate amounts of stomach are removed, (2) obstruction and gastric retention are prone to occur, and (3) leakage at the anastomosis is apt to occur. The first criticism can be answered by stating that if it is possible to perform an esophagoduodenostomy after total gastrectomy, it is certainly possible to utilize the duodenum after a subtotal resection. It is not generally appreciated that both the esophagus and pylorus are midline structures, less than 5 cm. apart anatomically. Further mobilization of the duodenum after the manner of Kocher allows it to be brought into the left abdomen without tension. The latter two criticisms are no more applicable to Billroth I than to Billroth II anastomosis. Leakage and stenosis are directly related to the care with which the technical procedure is performed.

In any discussion of Billroth I and II procedures, a few miscellaneous "facts" should be noted. Clinical analysis of large series of cases has not revealed an appreciable difference in the incidence of the dumping syndrome. However, in those patients who are disabled by a dumping syndrome following Billroth II operations, relief can be obtained for many by converting from Billroth II to Billroth I (Allen); also in cases of severe inability to maintain weight following Billroth II, conversion to Billroth I is recommended by many.[4]

In the face of the foregoing information, and partly because of our awareness of the imperfections of gastric surgery as we were performing it, it was decided three years ago to perform Billroth I reconstructions on some of our cases and determine for ourselves if it had the advantage so enthusiastically claimed by some of its advocates.

[3] Clagett, O. T. and Waugh, J. M.: Indications for and Advantages of Schoemaker-Billroth I Gastric Resection, Arch. Surg. 56:758 (June) 1948.

[4] Wallensten, S. and Göthman, L.: An Evaluation of the Billroth I Operation for Peptic Ulcer, Surgery 33:1 (Jan.) 1953.

Material

Thirty Billroth I procedures have since been performed, and it was for the purpose of reporting our experiences and opinions regarding this procedure that this study was done. Most of these were performed upon patients suffering from benign gastric ulcer. A few were performed after removal of the stomach for carcinoma and three following gastrectomy for duodenal ulcer.

The follow-up period is too short for us to form opinions concerning the long-term results. In our series of 30 cases, there was one death, which occurred in an 81 year old man who was operated upon as an emergency for massive hemorrhage from a huge carcinoma of the stomach. The Billroth I procedure was utilized in this instance because it can be performed in less time, and haste was urgent because of the poor condition of the patient. He expired a few hours after surgery from irreversible shock, and death was in no way related to the type of procedure. One patient developed a non-functioning stoma and required re-operation. A gastrojejunostomy was performed and repeat x-ray studies three months later revealed the gastroduodenostomy still completely closed. This patient had multiple superficial erosions associated with a marked active gastritis and subsequent to the second operation had a massive hemorrhage from which he recovered with transfusion alone. Although the pathology might have been a factor in the stormy and complicated course in this case, it served to convince us that it was mandatory to use fine interrupted sutures in a two layer (only) anastomosis, since this anastomosis had been performed with several layers of continuous chronic catgut, a practice which is not followed by any of the surgeons using this procedure at this time.

In the remaining 28 cases, the hospital course was particularly gratifying. There were no other major complications and no wound infections. Average hospital stay was eight days and the results of a questionnaire sent out to these cases are tabulated below.

Of the 30 cases, three have been done so recently that no letter was sent to them; all three had uncomplicated courses and are well at the present time, however. Two patients are dead; one died in the immediate postoperative period, as mentioned above, and one died six months postoperatively. Both had carcinoma of the stomach. Two other patients upon whom palliative resections for carcinoma of the stomach were performed are alive and subjectively well but were not included in the questioning. Two patients failed to answer their questionnaires.

Deor Potient:

The Surgery Deportment of the Stroub Clinic is conducting o survey to analyze the results of surgery of the stomach in recent years in this community.

Since you have hod an operotion upon your stomach, we would appreciate it greatly if you would come into the Surgery Deportment of the Straub Clinic for examination by Dr. Jomes Cherry, who is conducting this study. If this is not convenient, will you please onswer the following questions and return the letter in the self-addressed stamped envelope, which is enclosed for your convenience. Naturally, no fee will be chorged for the examination.

Sincerely yours,

1. Hove you kept well since your operotion? Yes..... No.....
2. Con you eot os much food os you wish? Yes..... No.....
3. Con you eot ony kind of food? Yes..... No.....
4. Is your oppetite good? Yes..... No.....
5. Are you oble to do full work? Yes..... No.....
6. Hos your weight been constant since the operotion? Yes..... No.....
7. Whot is your present weight?..... Your normal weight?..... Your highest weight?.....
8. Are you troubled with fatigue, cold sweats, paleness or abdominal poin after eating or did you have ony of these symptoms ot any time ofter your operation?.....

Signed:.....

FIG. 3.—The questionnaire sent to the patients in follow-up studies.

Analysis of Questionnaires

Eighteen of the 20 patients stated they had kept well since their operation. One patient answered this question, "No," but stated that his illness was not related to the stomach, and one patient was ill as a result of the dumping syndrome.

Thirteen patients answered "Yes" to the question, "Can you eat as much food as you wish?"; seven answered, "No." To the question, "Can you eat any kind of food?", 13 answered, "Yes," seven answered, "No." Eighteen patients stated that their appetite was good; two answered, "No." Fifteen patients were able to do full work; three answered, "No," one answered, "Just about;" one patient was already retired.

Three patients weighed more than their normal average at the time of questioning; nine had regained their normal average, making a total of 12 of the 20 whose weight gain was satisfactory. Eight patients were from 7 to 22 pounds under their normal average weight; three of these were 20 or more pounds below their normal average weight; two were between 15 and 20 pounds below their normal average weight; and three were from 7 to 10 pounds under normal average weight.

Twelve patients had no symptoms whatsoever at any time suggesting the dumping syndrome; two had transient symptoms immediately postoperatively which subsequently disappeared; four patients occasionally have symptoms suggesting the dumping syndrome; and two continue to have moderate-to-marked symptoms which are undoubtedly due to dumping.

Eighteen of the 20 patients who responded to the questionnaire were leading comfortable, active lives and might be considered to have a good final result following their gastrectomy. One patient was disabled (by radiation sickness) and had retired from his job; he had not regained weight, and had symptoms suggestive of a moderately severe dumping syndrome. The other patient was a medically indigent patient who gave a negative answer to every question asked but did not elaborate upon any of the questions.

Discussion

In studying the overall group of patients, we feel the single death in this series should not be considered when comparing Billroth I to Billroth II results, since this death occurred in an ancient patient (with a massive carcinoma, in a preoperative condition which was moribund) and was not related to the type of procedure. Serious complications were limited to one patient who developed a stomal obstruction in the postoperative period, and we believe this might be attributed to a technical feature which we do not utilize in our current operations; namely, multiple rows of continuous sutures of catgut. Our observations on weight gain after Billroth I procedures admittedly disappointed us, but failure to gain weight following gastrectomy does not in itself represent a poor result. One of our patients was still troubled by symptoms which we interpret as being due to the dumping syndrome, and this of course we count as an unsatisfactory result.

On the other hand, we were particularly gratified by the rapid recovery from and minimal reaction to surgery in this whole group. The period of hospitalization was shorter, and in terms of patient satisfaction, we believe this group compares favorably to any average group of patients who have undergone major gastric surgery. Technically speaking, we find the procedure is definitely faster and easier than Billroth II procedures in our hands.

We are not ready as yet, however, to recommend its use in all types of gastroduodenal pathology. Although we were satisfied with its use in a few cases of duodenal ulcer, these were selected cases in which the distortion and fibrosis of the duodenum were minimal and at least in our hands we feel it will find its most useful application in gastric ulcer for the present.

Conclusion

Gastroduodenostomy is a technically simple, safe, and satisfactory method of restoring gastrointestinal continuity following gastric resection. Follow-up studies indicate satisfactory results in approximately 90 per cent of the patients interviewed. The incidence of the dumping syndrome and failure to gain weight following this procedure does not seem to be different from that following other types of gastrectomy.

Addendum:

Since this article was written, an additional fifteen Billroth I gastrectomies have been performed, and while we do not feel that it has solved our problems in respect to weight gain after surgery and dumping symptoms, we continue to be pleased with the benign postoperative course following the procedure, the low incidence of complications, and the technical ease with which the procedure can be performed.

1020 Kapiolani Street.

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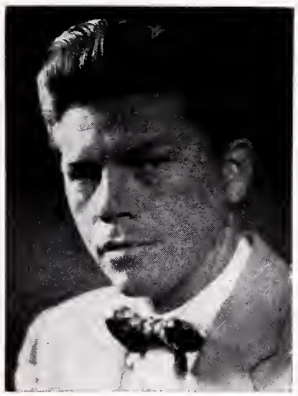
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DERMATOLOGICAL HAZARDS OF THE PINEAPPLE INDUSTRY

C. V. CAVER, M.D., Honolulu

The dermatological "hazards" of the pineapple industry seem on careful inspection to be virtually non-existent.

AN "ON THE SPOT" investigation, as recommended by M. H. Samitz,[1] was carried out in making a study of the dermatological hazards of the pineapple industry in Hawaii. Since there is a great deal of duplication and overlapping of processes by producers in this industry, the Hawaiian Pineapple Company, Limited, was chosen as the most representative and diversified field of study for this project. This one company has a total of about 4,300 permanent employees and during the peak season employs as many as 9,000. There are approximately 26,000 pineapple workers in the entire Territory of Hawaii on thirteen plantations and in nine canneries. A majority of these are represented by the International Longshoremen's and Warehousemen's Union.



DR. CAVER

The operations of this vast industry are roughly divided into two categories: the plantation division and the cannery division.

Plantation Operations

As complete a study as possible was made of all phases of operations required in the 18 to 24 months necessary to produce mature fruit. The sources of fruit for this company are the plantation at Wahiawa on the island of Oahu and the plantation located on the island of Lanai. Both properties are owned by the Hawaiian Pineapple Company.

Soil Preparation

Old fields ready for replanting are plowed with a rig composed of a tractor with a side plow and an attached stump cutter. The stump cutter is composed of two rows of discs for chewing up and grinding all old plant materials which are left on the ground. The field is then left for several months to allow decomposition of the plant material to take place. It is then harrowed and a lime coat of calcium carbonate (crushed coral) is added. This is dropped from spreaders which are pulled by tractors. The lime itself is delivered by trucks into a field dump where it is loaded into the spreader by a scoop mounted on the front of the tractor. There is apparently very little difficulty from dust inhalation or exposure of the skin to the calcium carbonate. This is due to the inert quality of the substance. In this form the lime is highly hydrophilic and presents no real hazard. The field is then harrowed three or four times before planting.

Nematode Control

The soil fumigants which are used in this process are D-D (mixture of dichloropropane and dichloropropene) and EDB (ethylene dibromide). Both are highly irritating to the skin and lungs, but do no harm, since injection into the ground by a closed system is employed. EDB is carried in a tank, mixed with diesel oil, while D-D is a ready mixed liquid.

There is apparently no hazard from the injecting machines when they are running normally, but there is a possibility of hazard in the mixing plant and with the bulk operators. Because of this, the men are equipped with chemical respirators and, wherever possible, with gloves of leather or synthetic rubber. Whenever exposure occurs, it can be removed by simple and immediate washing with water. Chloropicrin was formerly employed but is no longer in use.

Planting

Planting material is of three types: a slip, a sucker, and the crown. Slips are the stalks of the plant which occur below the fruit itself. This material is preferred. A sucker grows below the stalk of the plant after the first harvest. Suckers from the lower part of the plant are used to start new

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[1] Samitz, M. H.: Dermatological Hazards, Industrial Med. 16:489 (Oct.) 1947.

fields when a fast crop is desired. Crowns are the spiny top of the pineapple fruit which are removed in the harvesting process.

After the first harvest of mature plants, the slips are allowed to sprout, and one or two months later they are removed and planted in new fields. A so called "ratoon" or second crop may be obtained by removing slips in order to give the lower suckers less competition for nutrients. A second crop of fruit then matures on the older plants.

Protective equipment used in this operation consists of leather gloves, wire screen goggles, leather cuffs, and aprons. There is apparently no difficulty in the use of this equipment. The hands of the workers do not even get wet or macerated from perspiration. Some of the men even prefer a little moisture in the glove in order to get a better grip during operations.

After the last harrowing process, a road survey is made. Large self-propelled machines are used to inject the soil fumigants and to lay long rows of tar paper. The edges of the paper are mechanically covered with soil to hold it down. The tar paper (or mulch paper) is laid to prevent the growth of weeds, maintain the moisture content and temperature, and to protect the new plants. Holes are punctured in the tar paper at appropriate intervals and planting material is inserted by hand.

Insect Control

The most frequently used insecticides are DDT and Malathion. These insecticides are sprayed on the fields by means of long booms extending from mobile equipment. DDT is generally used in water, but is occasionally emulsified with diesel oil, water, and a wetting agent (27-R). DDT is also used occasionally in aromatic oil, either Union Oil 42-76 or Standard Oil 5-AP. Another commonly used insecticide mixture is one consisting of DDT, 27-R, water, diesel oil, and pentachlorophenate. This mixture is usually sprayed on the edges of the fields to make a barrier against ants and weeds.

Parathion is no longer used, having been replaced by Malathion. From the standpoint of safety, Malathion is thought to be the best chemical produced for this purpose. All recommended safety procedures and residual limit values are more than adequately complied with. There is apparently no danger whatsoever from the use of this agent. DDT is not used for a minimum of three months before harvesting, in order to comply with allowable minimum DDT residual standards.

Weed Control

This is a continuous process. The most frequently used vehicle is composed of diesel oil, water, and a wetting agent (Standard Oil Company 27-R). Into this may be incorporated pentachlorophenate, CMU, DDT, etc. Pentachlorophenol is mixed with sodium hydroxide at the mixing dump station in order to produce the phenate.

There has apparently been some difficulty in the past in handling sodium hydroxide. Since the introduction of face shields, plastic impregnated gloves and dust respirators, there have been no further difficulties. Dust respirators are used throughout the operations whenever any powdered materials must be handled. In general aprons are not used in these operations. None of the workers spoken to felt that they would be of any particular advantage.

A frequently used herbicide, Karmex W (called CMU), which is 3- (p-chlorophenyl)-1-1 dimethylurea) is used in water solution. This material has a very high residual limit value and no special precautions are considered necessary. TCA (sodium trichloroacetate) is a grass killer used to control Bermuda grass. This chemical is used in water and is sprayed in the same manner.

Dermatitis has been known to occur when workers in the field were accidentally sprayed with these solutions. One case of dermatitis is known to have occurred when a spray operator playfully administered a thorough wetting to an acquaintance as he passed by. The process of residual weeding is done entirely by hand after the spraying takes effect. This is known as "hoe *hana*," and is considered one of the easiest jobs available to plantation workers.

Fertilizing

Elements introduced are potassium, nitrogen, and phosphorus, which are applied mechanically near the base of the plant in the form of solid or liquid commercial fertilizers. This is done two to three months after planting has taken place. The substances are mixed on a truck but the bags of solids are loaded on to the truck by hand, opened and dumped by hand. Substances used for the fertilizing process are ammonium phosphate, superphosphate, potassium sulfate, urea, and ammonium sulfate. Ferrous sulfate has also been sprayed on the plants as an additive in liquid ammonia, though this is not a current practice of the Hawaiian Pineapple Company. Again, the use of protective equipment such as gloves, goggles, respirators, and button-up clothing is common and is apparently adequate.

Fruit Regulation

In this process hormones are used in order to force all of the buds on the plants to bloom, thereby producing a higher fruit yield. The sub-

stance most commonly used is ANA (sodium salt of alpha naphthalene acetic acid). No trouble has been reported from the use of this chemical, since an average of only 20 grams per acre is applied. It is mixed in the field in a tank truck and is applied in an aqueous solution.

Harvesting

Harvesting is the most active and interesting phase of plantation operations. The ingenuity of the development engineers in this industry is manifested in the equipment and the time-saving methods employed in this process. A gantry constructed to fit over a moving flat bed truck is used and is operated by one employee. A long boom extends out over the rows of pineapple from the gantry. The workers follow along behind the boom and pick the fruit, remove the crown and place the pineapple on a conveyor belt running the length of the boom. The entire rig rests over a large bin on the truck and moves forward under the power of the truck. The pineapples are lifted into the bin by the moving conveyor belt on the boom.

When the bin of the truck is filled it stops and the gantry (harvester) lowers four legs by which it lifts itself off the truck. The truck drives off to the loading point and is immediately replaced by another truck which follows it under the gantry. The gantry is then lowered down onto the truck and the entire harvesting rig moves across the fields again.

At the loading point, the full bin is picked off the flat-bed truck by a Ross carrier similar to those used in the lumber industry. The empty truck then returns to the fields while the full bin is either stacked or loaded directly on to larger trailer trucks for direct transportation to the cannery.

During the picking operation, twelve workers follow each boom and handle the fruit directly. Leather gloves are used to protect their hands and goggles made of wire or glass protect the eyes. The principal difficulty encountered in this process is trauma from the sharp tipped spines of the pineapple plants and crowns. The workers are in general quite careful to protect their skin and eyes by the use of heavy padded clothing, goggles, and gloves for the hands. The trauma which results is known as a "pine-poke" and consists of a minute puncture wound which is only rarely complicated by the presence of a foreign body. The plant points encountered are indeed quite sharp but are fortunately not brittle enough to break off very frequently.

Dispensary and Medical Aid

In the fields supervisors are provided with first-aid materials. Workers are urged to report any accidents or illness immediately, whereupon they are transported to the dispensary in Wahiawa. A safety engineer is employed to circulate continuously throughout all phases of plantation operations to check on safety procedures and to correct any conditions wherein any potential hazards might exist.

Bathing and other sanitary facilities are quite adequate in the plantation housing areas but compulsory bathing before or after work periods is not enforced. An occasional and expected amount of trauma and burns is encountered from the use of all forms of equipment in this highly mechanized industry. Sodium hydroxide burns have apparently been brought entirely under control by the use of proper precautions. Pineapple pokes are apparently quite frequent but actually few workers regard them as sufficiently annoying to occasion a visit to the dispensary.

A well-organized program of immunization is maintained for all employees and consequently tetanus is not seen. The incidence of deep mycoses is very low, probably due to the development of communal resistance.

Cannery Operations

The company cannery is located in the industrial district of Honolulu and employs the most advanced, modern equipment available anywhere in the world. The machinery and floor plans are ingeniously designed to provide the greatest amount of efficiency that one can imagine. This is done so effectively that even when the operations are at their peak, the workers and supervisors do not appear to be under any strain or sense of urgency.

Fruit Receiving

As the trucks come in to the cannery areas from Wahiawa and from the Lanai docks, the bins of fruit are lifted off the truck beds by the same type of Ross carriers as are used on the plantations. The carriers stack the fruit according to sizes and origin. Other carriers then pick up the bins from the receiving area and convey them to the fruit dumping stations. The fruit is weighed and the trash is extracted. The trash is then weighed in order to determine the exact weight of the crop. The fruit is dumped onto a receiving belt, conveyed through a high pressure washing set up, to the graders, then to the Ginaca machines.

During this first phase, after fruit dumping, the quality control is kept by picking random samples from the receiving belt. The samples are checked for size, shape, and weight to see if any

biological changes are taking place as a result of using the same planting materials over and over again. All of the pineapples harvested each year are the descendants of the original batch of plants imported around the turn of the century. Some of the test fruits then go to a special machine which performs extraction tests on the content. The fruit content is tested to determine the amounts of pigment, acid, the quality, flavor, and "brix" (soluble solids calculated as sucrose).

The fruit next passes workers at the crown cutting station. Here workers stand ready to remove defective and deformed fruit. These workers wear gloves and occasionally aprons. At times the juice of the fruit gets splashed on their skin. This is not common, because at this point the fruit is still encased in its shell. The workers at this point of the operation remove any crowns which have not been removed in the field. Any multiple or extra crowns are chopped off by hand. Straight crowns which had not been removed in the field are removed by a machine very similar to a bacon slicer.

The fruit is then graded and the different sizes are dropped onto appropriate cross conveyor belts which go to the Ginaca machines designed to core and peel the different sized fruit.

Ginaca Operations

The first Ginaca machine was invented in 1913 by Henry Ginaca, an employee of the Hawaiian Pineapple Company. It is an amazing mechanism which removes the shell of the fruit, and the core, and cuts off the ends, all in one operation. The result is a cylinder of pineapple ready for trimming and slicing. There are 48 Ginaca machines in a row. Fruit from the distribution belts is passed down a chute to the Ginaca machines. The flow of fruit is controlled by a trigger plate on the chute which automatically opens and closes the entry according to the need. Each pineapple is loaded by hand into a ladder lift that goes into the Ginaca machine. While fruit going to the Ginaca machines is graded and directed to certain machines according to size, even if there is a variation the cylinders come out of the machine identical in measurement. Any fruit particles which remain in the shell are removed by the same Ginaca machine and are conveyed with the cores to a special chute. The cores and eradicated meat go directly to the juice plant. The end cuts and the empty shells go to the bran mill. The Ginaca machine cores, peels, and eradicates the fruit up to 100 fruit per minute. The workers who are in close proximity to the Ginaca machines experience only occasional difficulty from contact with the fruit or juice.

Preparation Department

Chutes from the Ginaca machines go to the trimming tables. Each Ginaca machine feeds fruit to two tables. There are sixteen women to each table. In this operation only women are employed because of their digital and manual dexterity. Any remaining eyes and other defects are trimmed and picked out of the fruit by hand. Special knives and corers are used in this operation and are frequently exchanged because of possible dullness. The debris from this operation joins the eradicated fruit from the Ginaca machines and is conveyed to the bran mill by a continuous belt.

Women on the trimming tables wear rubber gloves, cloth aprons, and caps. The latter are largely for product protection. Protective glasses do not appear to be needed. Both the supervisors and the workers feel that glasses are unnecessary.

After the fruit cylinders are trimmed, they are automatically sliced in a manner similar to the slicing of loaves of bread. The perfect slices are chosen by the quality yardstick of visual judgment and are removed from the conveyor belt and placed in cans. The imperfect slices are then made into half slices and tidbits. No one in this area is allowed to carry anything in the shirt pockets because of the possibility of endangering the product in process. Music is played intermittently in this area and the women seem to appreciate it very much.

The workers all use a commercial protective cream, Fend-U, on their arms above the rubber gloves to prevent "pineapple burns." The frequent use of this substance is compulsory for all workers. Workers in any part of the cannery may change their gloves as often as they feel that it is necessary. Glove carts are circulated among the employees wearing rubber gloves so that fresh ones are readily available to the women on the trimming and packing tables.

The open cans of fruit of all sizes are mechanically conveyed to the syruping and double seamer department where an inspector manually extracts any remaining defective fruit from the can.

Double Seamer Department

After the cans of fruit are filled, they are mechanically conveyed to the double seamer department whose function it is to add syrup to the cans, seal them and send them on their way by an elevator conveyor to the cooker department. Prior to syruping the open cans go through a "pre-vacuumizer" which forces out any air bubbles. Syrup is then added to an established level. In this department as in all departments throughout the company, glass cleaning papers and cleaning solutions are provided. In the double seamer

department workers wear rubber boots. Rubber gloves are not necessary due to the fact that the workers are not handling the raw product. Workers occasionally wear leather or neoprene gloves.

The can lids are automatically placed upon the cans, and are then passed to the conveyor which takes the sealed tins of fruit to the cookers.

Cooker Department

The cookers look like large boilers lying on their sides, five feet in diameter and about fifteen to twenty feet long. The cans are spiraled through the cookers for five minutes at 220° F, but are not cooked under pressure. The area for cooking has ceiling vents to lower the temperature which averages around 85 to 90° F. In general the atmosphere is not oppressive and the workers do not appear to be uncomfortable. Ice water and salt tablets are available at many points throughout this department.

The cans are rolled out of the cookers at a high rate and into a cooling apparatus where a water spray cools them down to a handling temperature. The water used for this spraying operation is pumped out to the fruit washing station.

In both the Preparation Department and Double Seamer-Cooker Department the working areas are well ventilated from the ceiling and the environment is generally quite pleasant. No studies have been made for content of the air in this area but there appears to be no difficulty from dust, esters or humidity.

Locker Rooms

Lockers are provided for each employee and there are more than an adequate number of showers. Soap of any brand or type is sold at cost to the employees. No compulsory showering or other procedures are in effect, but about 50 per cent of the employees bathe after leaving their shifts. They are not required to shower before going to work and only a small number do so. An adequate number of urinals and wash basins is also provided.

The women's locker room is essentially the same in provision of facilities. Both locker rooms have Fend-U sprays which have been constructed by the company. The apparatus is composed of a battery of six sprays suspended over a sink and operated by manual pressure. Someone stands by to be sure that employees spray the protective lotion on their skin adequately before going in to the working areas.

The sanitary status of the entire cannery is excellent, although the operation of packing pineapple brings about sanitary problems in some sections of the plant.

There is a utility crew which cares for weeds outside of the main buildings, and other crews are organized to take care of microsol fogging operations for insects, while another centralized clean-up crew washes down the cannery after a day's operation. The rodent problem is kept under control by one man.

Juice Plant

The Juice Plant (which includes the extraction department) is an entirely mechanical operation, so that no juice or other pineapple product is handled by any employee. The eradicated pineapple from the Ginaca machines and from the trimming tables is brought to the juice plant on a conveyor belt and goes through stages of pressing. The pulp is then transported to the bran mill and the juice itself goes through centrifuges and is finally processed in the cans.

Glove Room

Circulating carts carry clean gloves from the glove room to the work areas and at the same time pick up discarded gloves. Workers are permitted to change gloves whenever they wish to do so. No pre-employment tests are made for sensitivity to rubber or substances used in the gloves but pre-employment observation is made during the training period. Applicants who have chronic eczema of the hands or other suspicious dermatoses are observed by the company personnel and are not employed for this reason. Gloves of both natural and synthetic rubber are used, with no apparent difficulty from agerite alba. Supervisors and plant officials were unaware of the possibility of induced leukoderma from exposure to the monobenzyl ether of hydroxyquinone, since no cases had occurred.

Most of the gloves used have knit cotton liners. Some of the older types are made of a kind of rubber-impregnated jersey. The employees work-

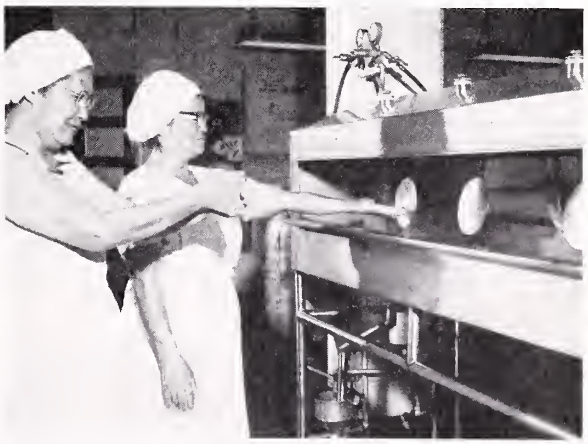


FIG. 1.—Spray machines, operating at the touch of the finger, provide protective lotion for cannery employees' hands at Dole Hawaiian Pineapple Company, Ltd.

ing on the trimming tables wear lined gloves, while those working in the packing and canning areas wear unlined gloves. As the gloves come into the glove room, they are taken to a steam sterilizer and subjected to sterilization. Several women are engaged in putting the gloves into tap water for the purpose of testing them for leaks as well as rinsing them after use. The gloves are blown up to check for leaks. The gloves are then turned inside out and are put in a hot air dryer. When the gloves are dry, they are powdered with soapstone in a revolving drum. Linit starch, "Nu-Skin," and other substances may be used for certain employees who prefer them. Gloves are patched like tire tubes, with small rubber squares. Employees are invited into the glove room to observe all of these precautions.

Bran Mill

None of the juice extracted from this department is canned or sold. Only by-products are made from this operation. The shells, end-cuts and other fibrous debris come in on a conveyor belt to a separator which removes any metal, rock, etc. The material then goes through a shredder and then into two presses. From there it is dropped in the bran bin. The rate of flow from the bran bin is controlled by hand shovelling. The moist bran is put through revolving dryers, and, when completely dried, is sacked. The sacked material is divided into two grades and sold as either cattle feed or pig feed.

Juice which is extracted from the solids goes through a heat exchanger where the temperature is raised to 135° F. The juice is mixed with Dicalite (amorphous diatomaceous silica) and sucked into a revolving drum through a thick layer of canvas. The process is called an Oliver pre-coat filter. Workers in this area wear leather gloves and rubber boots. The temperature varies between 85° and 90° F. The residue and Dicalite are discarded, and the juice is sent to liming tanks where the pH is adjusted to 5.3 as the mixture is agitated. This results in the formation of calcium citrate. By passing this mixture through a filter (Sweetland filter) the calcium citrate is removed, made into a slurry by the addition of water, and forwarded to the citric acid plant. The filtrate, known as clarified juice, is pumped to the ion exchange plant.

Ion Exchange Plant

The function of the ion exchange plant is to recover sugar in solution from the clarified juice by the use of anionic and cationic resins. The clarified juice passes through cation and anion exchangers. The cation exchangers remove the metallic ions and the anionic resins remove the anionic constituents along with most of the undesirable colored materials. The sugar components pass through unchanged. The end result is a water-sugar solution. When its percentage of sugar (as sucrose) is too low for it to be used as syrup for fruit processing, refined sugar is added to bring the concentration up to the desired strength. The entire ion exchange plant is mechanical and workers are under no skin hazards.

Freezing Room

In recent years a freezing plant has been added to facilitate handling the large amount of frozen pineapple products. Concentrated pineapple juice, chunks, and tropical fruit cocktail (all raw products) are frozen in a tunnel at minus 40° F. on a moving belt. Afterward they are cased and stored at 10°. There appear to be no dermatological problems in this department.

Container Plant

The Hawaiian Pineapple Company, Limited, imports large rolls of paper from the mainland and manufactures its own containers. The crimping and assembling operations are entirely mechanical. The container material is creased and cut to shape and folded into flattened containers which are then sent to the labeling and casing departments. The printing of the containers is done on roller presses in the container plant. Only two inks are used, red and blue. The inks are in a varnish base and generally are not handled by workers. Kerosene and white gasoline are sometimes used to clean the ink rollers. The paper tape which is used to reinforce the containers is coated with a sticky latex emulsion. Silicate of soda is used as a glue to bind three layers of paper together into the container material. A specialist cuts letters and designs and sets up the rollers for the printing machines. Goodyear's Pliobond Adhesive is used to mount the letters on the rolls. Occasionally a solvent known as Fedroid ink roll cleaner is used on the ink rollers. The only other chemical hazard encountered in this department is caustic soda which is sometimes used to clean out the ink buckets.

Labeling and Case Goods

All operations are mechanical in this department. The arrangements have been made so safe and efficient that a number of blind workers are employed here. The flat cases which come in from the container plant are sucked open into shape by vacuum. No chronic dermatoses, injuries, or stigmata were observed.

Concentrated Juice Plant

In the manufacture of concentrated juice, it is necessary to extract the esters which are responsi-

ble for the flavors. The extraction must be done before the concentrating goes into effect. Esters themselves are highly volatile and would be easily lost through the heating of the juice. The juice is heated to 135° F and the esters are extracted by vacuum. The vapor at the lower atmospheric pressure contains the esters. The esters are caught, cooled, condensed, and stored in a cold wall (refrigerated) tank. The ester (or essence) is then returned to the juice after it is concentrated. The amount of esters returned is determined by constant laboratory testing so that the concentrated juice will be of uniform flavor and quality throughout the canning year. The entire operation of extraction and distillation is accomplished in an entirely closed process and appears to offer no hazards.

Dispensary

A conference with the chief nurse of the large and adequate dispensary revealed that although records are kept on all conditions treated, they are not classified as to types. For instance, treatment for skin conditions is not recorded separately and it would, therefore, be difficult to analyze the records for the rates and incidences and types of skin disorders.

In general, the opinion is that traumatic lesions are uncommon.

They have also had very few cases of sensitivity from oils and petroleum products which are used in the company garages and maintenance areas. This is apparently due to the fact that the "dry" type of Kerodex silicone protective cream for the skin is used by these workers.

Some of the workers who wear rubber gloves for long periods of time occasionally experience some difficulty with soft nails and very occasionally have active paronychia. Very few of them suffer from fungus infections of any kind. There are occasional abrasions, puncture wounds, and lacerations of the arms and hands and a few on the feet.

It has been mentioned before that there is rarely any difficulty resulting from splashes of pineapple juice in the eyes or on the skin. In the event it is splashed in the eyes, it is washed immediately with saline. By using this treatment, there seems to be no difficulty with enzymatic digestion. Any of these injuries which persist to the second day are referred to an eye specialist of the patient's choice.

The principal difficulty encountered in the dispensary is the so-called "pineapple burn." Sometimes these are due to friction of the glove rim, but for the most part they are due to protein digestion of the skin from the proteolytic enzymes found in the pineapple juice. The enzyme known to cause pineapple burns has been identified as bromelain. While a pineapple burn will occur in some cases when the skin is exposed to the enzyme in the juice, any friction will enhance the chemical action. The first sensation of a pineapple burn (even when friction has not occurred) is a feeling of tingling or of paresthesia about one-half hour after the juice has come in contact with the skin. Erythema is always evident and sometimes there is a primary and occasionally secondary burn with a few vesicles. Pineapple burns observed on the spot in the dispensary consisted of shallow excoriations which involved the epidermis and possibly the dermal papillae but showed very little secondary inflammatory reaction around the edges.

This condition is never encountered where Fend-U has been used on the skin. Employees who believe that their burns or irritations are due to the Fend-U itself are patch-tested. To date no positive reactions have been noted.

The usual treatment for pineapple burns in the Hawaiian Pineapple Company dispensary is an application of 2% allantoin cream immediately after the burn is washed. A few of the burns are treated with a paste containing 5% sodium propionate with a small amount of chlorophyll added. Apparently the mode of action of these two substances is to create a microscopic debridement of damaged cells and thereby enhance the reepithelization of the skin. The results appear to be very satisfactory if the treatment is applied immediately. Very few of them persist beyond the second day. Employees almost invariably consult the dispensary immediately on suspicion of pineapple burns. It is safe to say that almost none of them feel that it is necessary to go to a private doctor or even to have the company doctor called in for observation of these lesions.

Summary

By means of field inspection a survey was made of the hazards to the skin in the pineapple industry. Due regard was given to present practices and facilities and to possible situations which might arise in the future. In an industry where one would reasonably expect a high rate of industrial dermatoses and skin problems it was found that these problems are in general minor or well under control.

The only remarkable finding of the study was the high level of cognizance of hazards to the skin, the progress made, and precautions used in their elimination or control.

1154 Bishop Street.

EXCRETORY UROGRAPHY

In Diagnosis of Urinary Bladder Lesions

R. G. RIGLER, M.D., AND W. S. STRODE, M.D., Honolulu

EXCRETORY UROGRAPHY is a commonly employed, relatively uncomplicated office procedure which gives the clinician detailed and reliable information regarding the function and structure of the urinary tract. In our opinion, all patients exhibiting microscopic or gross hematuria should be evaluated initially by intravenous pyelography.



DR. RIGLER

Hematuria is often due to urinary bladder lesions, of which bladder neoplasms are the most important and serious. In addition to bladder tumors, the differential diagnosis of filling defects seen on cystograms includes these several following possibilities: (1) non-opaque stones; (2) foreign bodies; (3) prostatic hypertrophy; (4) bladder wall trabeculation; (5) diverticula; (6) prolapsing ureterocele; (7) extrinsic pressure defects; (8) overlying air and feces in the sigmoid; (9) hypertrophied interureteric ridge; (10) hemorrhagic cystitis with edema; (11) blood clots; and (12) endometriosis.

Too often, the appearance of the bladder is only superficially scanned during film interpretation and is neglected because of more attention directed toward the kidneys and ureters. Recently improved radiographic media which produce greater film density and contrast have increased the diagnostic yield of excretory cystograms. Therefore, it is of greater importance to carefully evaluate the bladder. Intravenous Hypaque and Renografin often produce cystograms in which the density approaches that of retrograde studies.

In our experience, the excretory cystogram has been of great value in detecting space-occupying bladder lesions. The following examples amply illustrate the value of the procedure and the need for close scrutiny of the roentgenograms.

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Excretory urography may make cystograms unnecessary, though it is not a substitute for cystoscopic examination.

Case Reports

Case 1.—Mrs. S. T., a 49 year old white woman, was first seen on May 7, 1956, because she had noted blood on the toilet tissue after urination for the previous three or four days. She had occasionally noted the same thing for the past several months. There were no urinary symptoms whatsoever. She denied true gross hematuria.

General health was good. Physical examination was entirely within normal limits. Catheterized urine was completely normal, without microscopic hematuria or infection. Blood urea nitrogen was normal.

The following day, excretory urograms were made and these revealed a normal upper urinary tract. There was an obvious irregular filling defect in the left portion of the urinary bladder (Fig. 1). The irregularity indicated an extremely papillary type of tumor. Cystoscopy the same day revealed a papillary, villous, superficial tumor of the left lateral bladder wall just lateral to the left ureteral orifice, 2 cm in diameter. There was a tiny 3 x 4 mm papillary lesion immediately above the right orifice. The remainder of the bladder was clear. A diagnosis of two papillary carcinomas of the bladder, clinically Grade I, non-infiltrating, was made. The patient was admitted to The Queen's Hospital on May 13, 1956, and the following day the lesions were resected and the bases thoroughly fulgurated. Pathological report was Grade I, transitional cell, papillary, non-infiltrating carcinoma of the urinary bladder.

The patient has had no further hematuria since transurethral resection was done. Follow-up cystoscopic examinations on July 2 and September 11, 1956, showed well-healed scars at the sites of the former tumors. There was no evidence of recurrence.



FIG. 1.—Case 1.—Excretory cystogram. Irregular filling defect, left lateral wall.

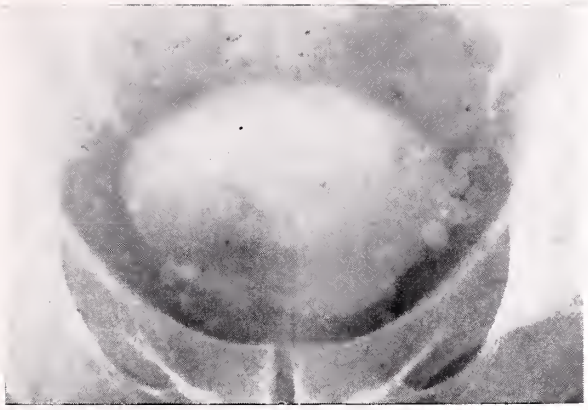


FIG. 2.—Case 2.—Excretory cystogram showing large, indefinite filling defect, right side of bladder.



FIG. 3.—Case 2.—Retrograde double-contrast cystogram. Mass clearly demonstrated on the right.

Case 2.—Mr. A. F., a 56 year old white laborer, was first seen in the General Surgery Department on May 31, 1956, because of a right inguinal hernia. At that time he stated he had been passing blood in his urine off and on and was therefore referred to the Urology Department. Apparently he had had intermittent painless gross hematuria for approximately one year. Three months after onset, he came under the care of a Chinese herb doctor who had attended him at intervals until the present time. The hematuria was frequently terminal but at times was total. He also complained of nocturia three to four times a night for as long as he could remember. Otherwise his general health had been good.

Physical examination revealed a hypertension of 250/150, but otherwise was entirely within normal limits. The prostate, rectally, was small, firm and benign. The bladder base was negative for neoplastic mass. A second glass urine showed 2 plus albumin, occasional pus cells and many red blood cells in the sediment, and stain of the sediment revealed occasional pus cells and occasional bacilli. Blood urea nitrogen was 15.5 mg per cent. Complete blood count was essentially normal but a sedimentation rate was 28 mm in one hour. Chest x-ray was negative.

On June 5, 1956, excretory urograms revealed a normal upper urinary tract except for a duplication on the right. There were some irregular calcifications in the bladder area and the excretory cystogram outlined an indefinite fairly large filling defect in the right side of the bladder (Fig. 2). Cystoscopy done on the same day revealed a large, partly necrotic tumor on the dome of the bladder about 3 cm inside the vesical neck to the right. There was another tiny papillary tumor slightly behind this. Retrograde double contrast air cystogram confirmed the presence of a large filling defect in the dome of the bladder on the right side (Fig. 3). A diagnosis of carcinoma of the bladder, clinically Grade I to II, probably non-infiltrating, was made on the basis of cystoscopic findings. Since all of the lesion was in the dome of the bladder and well separated from the base, it was felt that segmental resection would offer a good chance for cure.

He was therefore admitted to The Queen's Hospital on June 12, 1956, and the following day the bladder was exposed through a suprapubic midline incision. A large mass could be palpated, entirely confined to the interior of the urinary bladder on the right side. The abdomen was opened and exploration of the para-aortic and iliac areas showed no lymph node involvement. The liver was normal. Therefore, a segmental resection of the bladder was done, removing a large portion of the dome with a wide margin of normal bladder alongside the lesion.

Pathological report on the tumor was Grade II, papillary, non-infiltrating, transitional cell carcinoma of the urinary bladder, multicentric.

He had an uneventful recovery from surgery and was cystoscoped again on July 30, 1956, at which time a healed scar of the bladder dome to the right of the midline was found. No evidence of tumor recurrence was present and the bladder capacity was 200 cc.

Case 3.—Mr. Y. T., a 76 year old Japanese man, was seen in the Medical Department on August 1, 1956, with a history of gross hematuria of one day's duration. General health had been good. There were no other urinary symptoms.

General physical examination was within normal limits. Blood pressure was 120/80. Prostate on rectal examination was normal size and benign and the bladder base was negative for tumor mass. Urinalysis was completely normal except for a few red blood cells in the wet sediment. The stained sediment was negative for infection. Blood urea nitrogen was normal. Excretory urograms revealed a normal upper urinary tract with a small filling defect in the right side of the bladder (Fig. 4). Cystoscopy on August 8, 1956, demonstrated two small, clinically Grade I, non-infiltrating papillary bladder tumors on the right lateral vesical wall. The larger one was 1 cm in diameter and the other was about 5 mm in diameter. The remainder of the bladder was clear.

The patient was admitted to The Queen's Hospital on August 12, 1956, and on the following day the tumors were resected transurethrally and the bases heavily fulgurated. Pathological report was Grade II, papillary, non-infiltrating, transitional cell carcinoma of the urinary bladder.

To date his recovery has been uneventful.

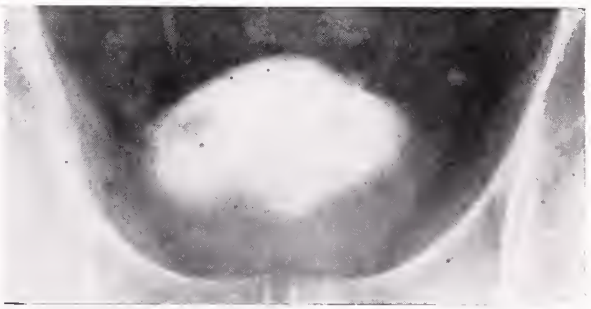


FIG. 4.—Case 3.—Excretory cystogram demonstrating small filling defect of right lateral wall.

Case 4.—Mr. J. T., a 59 year old white man, was first seen in the Medical Department on November 18, 1956, with a 10 day history of a urinary tract infection. Symptoms consisted of frequency, urgency, burning and low backache. There had been no blood in the urine. Routine urinalysis revealed 4+ albuminuria with many red cells and pus cells in the sediment. He was treated with Gantrisin for one week with considerable improvement. At the end of this time he developed gross hematuria with the passage of small clots in the urine but no pain. He was referred to the Urology Department at this time. His general health had been good except that he was known to have aortic valvular disease, probably on an arteriosclerotic basis.

Physical examination on the 28th of November was normal except for the rectal examination. The prostate rectally was small, firm, and benign. There was a soft, boggy mass above the prostate in the region of the right seminal vesicle. It was felt that this could either be a full vesicle which emptied poorly or possibly a bladder neoplasm of the base. Prostatic secretion showed no pus or blood but the urine was grossly bloody in both glasses. Blood urea nitrogen was 15.7 mg per cent, and a complete blood count was within normal limits. Excretory urograms done on December 1, 1956, showed a normal upper urinary tract bilaterally. A 3 cm irregular filling defect in the right side of the bladder seen on the excretory cystogram was non-calcified and had the appearance of a bladder neoplasm (Fig. 5).



FIG. 5.—Case 4.—Excretory cystogram showing an obvious filling defect in the right side of the bladder.

Cystoscopy on the same day revealed a 2½ to 3 cm round but papillary tumor just lateral to and above the right ureteral orifice, which was approximately 1 cm away and did not appear to be involved. The base of the tumor seemed quite broad but no surrounding infiltration was evident. Bladder capacity was normal and the remainder of the bladder was clear. On bimanual palpation a movable mass corresponding to the tumor seen on cystoscopy was felt.

A diagnosis of carcinoma of the bladder, clinically Grade I and probably non-infiltrating, was made on the basis of cystoscopic and x-ray findings. A chest x-ray was negative without evidence of metastases. Electrocardiogram was essentially negative. He was seen by the Medical Department for pre-operative study, and examination revealed a fairly loud systolic and diastolic apical murmur. A diagnosis of arteriosclerotic heart disease was made and he was thought to be a substandard risk for his age.

He was admitted to The Queen's Hospital on December 6, 1956, and the following day transurethral resection of the bladder tumor was done. Under anesthesia it immediately became evident that the tumor was more malignant than was originally believed. The surface of the tumor was papillary and many low grade areas were seen at the periphery. However, the bulk of the tumor itself was quite solid and definitely was infiltrating the vesical wall. Bimanual examination revealed an entirely soft pelvis and bladder wall without any evidence of induration or extension of the tumor.

The tumor was resected down to and deeply into the bladder wall in all areas but particularly in the center where deep infiltration was present. It was necessary to resect the distal one-half of the intramural ureter in order to deeply remove the center of the tumor. Following resection the base was heavily fulgurated in all areas. An attempt was made to leave a ureteral catheter indwelling in the right ureter following fulguration but the orifice could not be found even with the help of indigo carmine because of the heavy fulguration. However, the patient had an uneventful recovery from the surgery.

Microscopic examination revealed a Grade III transitional cell carcinoma, invading the bladder wall in many areas. In view of this fact, it was felt that segmental resection of the bladder and reimplantation of the right ureter should be done in order to give the patient every chance of cure.

Therefore, on December 14, 1956, the right half of the bladder was removed, providing a 2 cm margin around the area of fulguration, and the right ureter was reimplanted into the bladder. Exploration of the abdomen was negative for evidence of distant metastases or lymph node involvement. Pathological report on the removed segment of bladder showed no residual tumor in any area. The patient is still recovering from surgery at the time of this report.

Comment

All authorities properly urge caution in over-interpreting bladder filling defects present on excretory cystograms, because of the frequency of incomplete distention of the bladder by media. We feel that the value of excretory cystograms has been under-emphasized in the literature and textbooks. While it is true that a normal-appearing bladder does not exclude tumor, we believe that a space-occupying lesion, if present, is frequently demonstrated.

Conclusion

We have found that the excretory cystogram has often initially demonstrated the presence of a bladder tumor. We feel that this is partly because of improved intravenous urographic media, dual interpretation of roentgenograms, and close cooperation between the radiologist and urologist. We urge that careful attention be directed to the cystogram during the interpretation of excretory urograms. It should be emphasized, however, that the excretory urogram is not a substitute for cystoscopy.

1020 Kapiolani Street.

Case Reports

CARCINOMA OF THE COLON

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It is believed that the following case report has enough features of interest to make it worthy of recording.

Case Report

A 50-year-old Japanese man was first seen for his present symptoms on August 19, 1955. He complained of recently being weak and tired, and his friends had told him he had a poor color. He had no other symptoms, particularly no change in bowel habits, and he had noticed no blood in his stools. His blood count done elsewhere had shown 3,200,000 red blood cells and 6.2 grams of hemoglobin.

On January 1, 1951, I had done a high gastric resection for intractable duodenal ulcer. The duodenum was involved with extensive scar tissue, the result of years of inflammatory reaction, and the ulcer had penetrated into the head of the pancreas. Under these circumstances, it seemed inadvisable to attempt removal of the ulcer. The pylorus was severed about 1½ inches proximal to the duodenum, and the gastric mucosa was cored out down to the duodenal mucosa and the pylorus closed. This was followed by removal of about 75 per cent of the stomach. A retrocolic isoperistaltic Polya-Hofmeister type of anastomosis was done.

While it is unusual for a patient with a stomal ulcer not to have pain, it was felt that this was a possibility in causing the patient's anemia. An upper gastrointestinal study failed to reveal anything suggesting such a diagnosis. The patient's chest x-ray and urine examination were negative. On a meat-free diet, occult blood in the stool was 2 plus. A colon x-ray study on two occasions showed an obstructing lesion in the region of the hepatic flexure (Fig. 1) and a provisional diagnosis of carcinoma of the colon was made.

At operation, a lesion of the hepatic flexure was found which had involved the fundus of the gallbladder, necessitating its removal with the resected colon. The lesion had also involved the anterior wall of the duodenum directly over the ampulla of Vater. This was verified by frozen section. Since the liver and other structures, especially the lymph nodes, seemed to be free of metastasis, the duodenum, over to the superior mesenteric vessels, was removed along with the adjacent portion of the head of the pancreas. The last several inches of the ileum and the right half of the colon were removed along with wide resection of the mesocolon. The pancreatic duct and the common bile duct were anastomosed to the efferent loop of the jejunum as shown in the accompanying diagram (Fig. 2). The region of the pancreaticoduodenal anastomosis was drained through a stab wound to the right of the incision.

Several days postoperatively, it became evident that a fistula of the pancreas and of the jejunum had developed because of the large amount of bile-stained drainage and because the abdominal wall around the drains began to be digested. The Penrose drains were removed and two catheters were introduced into the depths of the wound, one size No. 12 and the other size No. 24. Suction was attached to the larger catheter. Into the other catheter a solution was dripped (15 to 20 drops per minute) consisting of tap water to each 1,000 cc. of which was added four bouillon cubes and 2 drams of dilute hydrochloric acid. Under this regimen the fistula healed and the tubes were removed at the end of three weeks. Otherwise the the patient made an uneventful postoperative recovery.

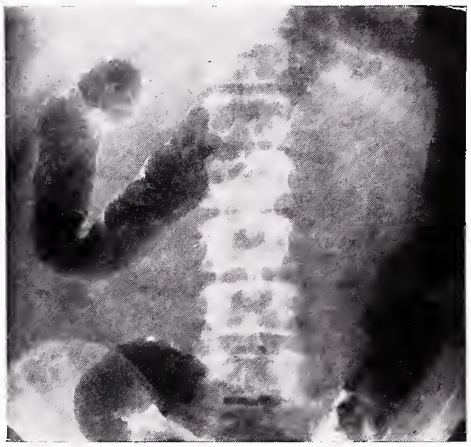


FIG. 1.—Showing obstruction of the hepatic flexure of the colon.

Discussion

There is much difference of opinion about the best method of handling duodenal ulcers coming to surgery that have extensive scarring and are surrounded by marked inflammatory reaction making their removal hazardous because of possible injury to the common bile and pancreatic ducts and the difficulty of adequately closing the duodenal stump. Some surgeons apparently are more adept at removing such ulcers and claim to do so successfully in virtually all cases. Not having the dexterity nor the fortitude to attempt removal of a fair percentage of such ulcers, I have in most instances relied on the method of exclusion of the ulcer, as carried out in this case. The results in my experience have been satisfactory. The apparent almost complete return of the duodenum to normal following this method of procedure in this case, and the absence of an anastomotic ulcer or other unfavorable complications, is a bit of evidence in favor of this method of procedure.

It has long been known that anemia is a frequent accompaniment of carcinoma involving the right half of the colon. This may be partly ex-

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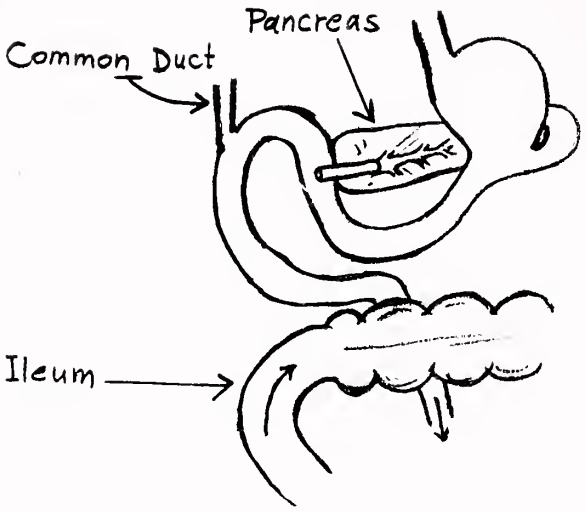


FIG. 2.—The type of reconstruction that was done.

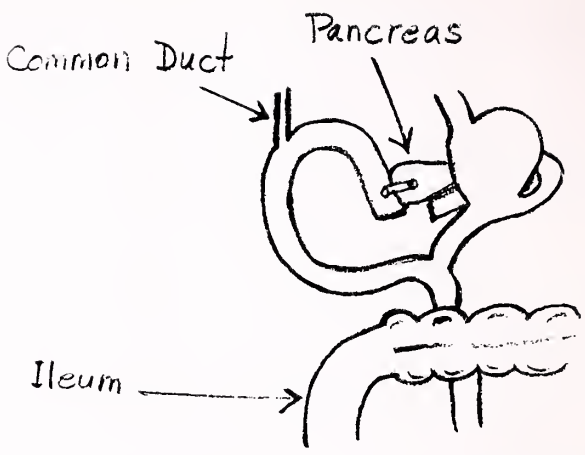


FIG. 3.—The type of reconstruction that would, under the circumstances, have been better. A type of reconstruction that permits alkaline bile and pancreatic secretion to bathe the gastrojejunal anastomoses is probably the most desirable in preventing the development of a stomal ulcer.

plained on the basis of loss of blood from the ulcerating area but undoubtedly other factors play a part. The possibility of such a lesion should not be overlooked when a patient comes under observation with anemia in whom the cause cannot otherwise be explained.

Reflecting on the conduct of this case, it would no doubt have been advantageous to sever the jejunum just proximal to the anastomosis with the pancreas, close the distal end and anastomose the proximal end to the jejunum well below the anastomosis with the common duct, as shown in Fig. 3. This would have allowed the patient to continue with oral feedings instead of having to resort to intravenous therapy and there probably would be less danger of an ascending hepatitis developing in the future. It is difficult to always think of procedures during an operation that come to mind as being of value during the postoperative course.

Anyone doing any considerable amount of abdominal surgery will sooner or later have the misfortune of having to cope with a duodenal fistula. If such a fistula is not handled properly, both as regards the patient's physiological needs and locally by application of measures to promote healing of the fistula, the patient may not survive. General measures consist of adequate intravenous administration of fluids, electrolytes, vitamins, and as much carbohydrates and protein as seems necessary or the portal of entry will permit.

The local care of the fistula is extremely important. One's objectives should be (1) to keep the wound as clean and free of duodenal content as possible; (2) to offset the action of the pancreatic enzymes; and (3) to furnish protein for the enzymes to act upon rather than to digest the patient's abdominal wall.

To accomplish the objectives mentioned, two soft rubber catheters should be introduced into the depths of the wound to as near the site of origin of the fistula as possible. One should be approximately size No. 12 French, the other size No. 24. Suction is applied to the larger catheter and into the other, a solution containing hydrochloric acid and protein is dripped.

Until recently, cubes of beef broth were used with the mistaken belief that they supplied an appreciable amount of protein. Since being disillusioned as to the benefits of beef broth in this respect, the following solution has been used which proved to be most effective, at least in one case: To 1,000 cc. of tap water is added 2 ounces of non-fat dry milk powder, and 2 drams of 10 per cent hydrochloric acid. This solution is dripped into the smaller catheter at the rate of ten to fifteen drops per minute. This solution, being acid, inhibits the action of the proteolytic enzymes arising in the pancreas which are accustomed to an alkaline medium. Theoretically, at least, the protein in the solution furnishes material for the enzymes to act upon rather than the abdominal wall and suction keeps the wound clean in addition, no doubt, to helping diminish the caliber of the fistula. In order to make the wound air tight and to protect the skin, zinc oxide is applied about the catheters in copious amounts.

The method just described of handling duodenal fistulas has been most effective in my experience. Certainly it is far better to close the fistula by these conservative measures rather than to attempt to cope with it surgically. It is never technically easy to attempt closure of such fistulas

by surgical means because of adhesions and edema, and the patients are usually poor surgical risks.

In this case, it is remarkable how extensive the lesion had become, and particularly how much invasion of surrounding structures had occurred, without producing more pronounced symptoms. The fact that the lesion took on characteristics of local invasion rather than of metastatic spread would seem to justify the radicalness of the operation and lend hope that the end result may prove to be satisfactory.

In conclusion, I wish to emphasize that in individuals who are anemic and in whom other examinations fail to account for this condition, the colon should always be adequately investigated.

1020 Kapiolani Street

TETANY CATARACTS

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The association of cataracts with various diseases such as tetany,[1] glomerulonephritis, and chronic atopic dermatitis has long been known. Tetany is the commoner cause, however, and while the case to be presented has aspects of all three of the above diseases, it is believed it would actually fall into the tetany group.

Case Report

A critically ill 15-year-old white girl was seen at the Children's Hospital on January 6, 1957. She had a three-year history of recurrent exacerbations of nephritis, which required hospitalization on several occasions. In October, 1956, she had developed a periapical dental abscess for which she received several penicillin injections. Shortly thereafter, she had a recurrence of epistaxis and periorbital edema.

On December 15, 1956, she developed a generalized vesicular rash and temperature elevation, but no edema was noted. On December 20, 1956, she was afebrile but had vomiting and diarrhea. She was hospitalized on December 27, 1956, at the Hilo Memorial Hospital with anasarca, epistaxis, and anemia. An exfoliative dermatitis was developing. Intravenous fluids, oxytetracycline (Terramycin), and prednisolone were prescribed. She had a convulsion on December 29, 1956, at which time the NPN was 270 mg per 100 ml and CO_2 10 mEq/liter. She was transferred to Children's Hospital on January 6, 1957, at which time she stated her vision had been diminishing steadily for about two weeks. Moderately but increasingly severe tetany was present, and persisted.

The laboratory studies revealed urinalysis typical of nephritis; no sugar or acetone was found. A marked anemia and leukocytosis were present. An LE preparation was negative.

Blood studies on January 7, 1957, revealed the following: NPN 225 mg %; Na 140 mEq; K 49 mEq; Cl 97 mEq; CO_2 6 mg %; and calcium 1.75 mEq. Phosphorus, phosphatase, and fasting blood sugar were not determined.

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[1] Cowan, T. W.: Tetany Cataracts, Straub Clinic Proceedings 22:166 (Oct.-Dec.) 1956.

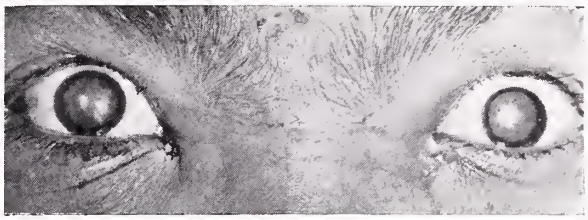


FIG. 1.—Bilateral tetany cataracts described in accompanying text. From Kodachrome transparency.

Examination of the eyes with the pupils dilated on January 8, 1957, revealed bilateral cortical cataracts, not quite matured (Fig. 1). The opacities in the posterior cortex seemed denser than those anteriorly. No fundus or red reflex was obtainable. The patient could perceive light and color, and had good 2-point discrimination.

Despite massive supportive therapy, the patient experienced a rapid down-hill course and expired on January 10, 1957.

Discussion

It is interesting to speculate on the probable cause of her cataracts. As has been mentioned, cataracts are seen in association with chronic atopic eczema (disseminated neurodermatitis) but usually only when the condition has been present ten years or more. The association of cataracts with nephritis has been noted. In nephritis, as in hypoparathyroidism, there may be decreased calcium and increased phosphate and phosphorus, and this is probably the actual factor in production of cataracts with nephritis. The low serum calcium, 1.75 mEq, certainly would be the most logical explanation in this case. It is unfortunate that the phosphate levels could not be obtained. In view of the short duration of the exfoliative dermatitis, I feel it can be discounted as playing any role in the production of the cataracts.

This case is presented as an interesting example of the production of rapidly maturing cataracts in a patient with acute nephritis, the actual causative factor probably being the production of a metabolic imbalance similar to that seen in hypoparathyroidism.

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Special Report

Some Practical Aspects of the Recently Enacted Disability Insurance Provisions of the Social Security Act

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The year 1956 marked an important development in the protection afforded by social security. For the first time in this country, the social insurance concept was extended to disability benefits on a national scale.

As you know, under the old-age and survivors insurance program, people who work for others or who are self-employed contribute to a fund during their working lives. Then, when they fall victim to certain economic risks, payments are made to them and to their families from the fund maintained by their contributions and the contributions that employers have made. [Actually, payments are made from *current* tax revenues.—ED.] The risks covered are the loss of earnings because of retirement in old age, death, and—most recently—completely incapacitating disability after the age of 50.

Until 1954, it was not uncommon for a worker whose working lifetime had been cut short by disability to find that the gap in his social security earnings record had resulted in greatly reduced benefit payments or in complete loss of eligibility. In 1954, the social security law was changed to permit a worker to "freeze" his social security record if he became totally disabled. The "wage-freeze" program, roughly analogous to waiver of premium in an insurance policy, was enacted to prevent the complete loss or significant reduction of old-age and survivors insurance benefits on account of long-term disability.

In 1956 Congress provided for the payment of disability insurance benefits to totally disabled workers[1] beginning at age 50, and for the payment of dependents' benefits to disabled adult children of insured workers, if these children were disabled before age 18 and continue to be unable to do any work. This past month—January, 1957—was the first month for which benefits from the old-age and survivors insurance trust fund ever became payable on the basis of eligibility by reason of disability. Several thousand of the first applicants for disabled dependent children's benefits are now in the process of receiving their initial checks. Also this past month, to cover the cost of the disability benefits program, an increase in the contributions rate by one-half of one percent became effective.[2] A separate trust fund has been established from which payments to qualified persons age 50 and over will be made, beginning with the month of July of this year.

Right from the start we sought advice from consultants and advisory bodies representing many fields of experience. We wanted to be sure that the policies and procedures we adopted would be sound from a social, administrative, and technical point of view. We were especially concerned that our processes would be thoroughly valid from a medical standpoint and would enhance doctor-patient relationships. It was this approach which led to the appointment by the Social Security Administration of a Medical Advisory Committee, a non-governmental group composed of members of medical and related professions with a common interest in the problems of the disabled. This Committee has served not only as a sounding-board, but its professional guidance and incisive estimates of medical problems are of continuing help in the development of policies and procedures.[3]

By adding the 1956 disability benefit amendments to the freeze, Congress gave us a much bigger job to do. Basically, however, the definitions under both provisions are the same, and the pro-

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[1] In order to qualify for either disability insurance benefits at age 50 or to have his social security record frozen, a worker must have social security credit for at least 5 years of work in the 10 years immediately before the onset of his disability, and at least 1½ years of this work must have been in the 3 years just before he became disabled. Moreover, beginning 7/1/61, the "cash" benefit work requirements become progressively more restrictive until disabled individuals may need to have (in addition to other requirements, e.g., the 6-month waiting period) as much as 10 years of social security credit. In substance, at the time of his disability, he must have a social security record of some years standing, and one which shows that he was recently a part of the Nation's labor force.

[2] One-quarter of a percent on employees and one-quarter of a percent on employers; three-eighths of a percent on self-employed individuals.

[3] While the function of the Medical Advisory Committee is to advise the Social Security Administration on the medical aspects of problems and policies of administering the disability program, this, in no way, implies a responsibility for passing on the desirability of legislation, either now or in the future.

cedures worked out for the one have been found applicable to the other.

Concept of Disability

In any discussion of disability, it is essential first to define our terms. The old-age and survivors insurance disability provisions define disability as "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or to be of long-continued and indefinite duration . . ."

While the definition prescribed in the law is in concrete terms, still, as in most statutes, it gives us the responsibility for working out its application through administrative interpretation. Criteria had to be devised to answer such obvious questions as: "What is long-continued and indefinite duration? Is the term to be used in the sense of "absolute perpetuity," "everlasting?" Or are we to interpret the phrase to mean merely "not temporary" or "not transient?" One clue to the answer was found in congressional discussions; there appeared to be an implicit understanding in those discussions that it is not sufficient for the disability merely to extend beyond the waiting period of six months required to screen out obviously temporary conditions; the condition should be likely to continue for the foreseeable future, or to result in death.

The concept of lack of capacity for "substantial gainful activity" is, of course, the most difficult element in the definition. In applying the definition to actual cases, we do not construe it to mean that complete and irrevocable helplessness must be demonstrated. However, congressional deliberation did indicate that the definition was intended to mean "total," in the sense that it refers to inability to engage in *any* substantial work, not merely the kind of work the applicant last engaged in, or the kind for which he is most obviously suited. Thus, an individual who has been advised to give up his particular kind of work in order to make his medical treatment more effective, or who finds he is no longer able to meet the physical and mental demands of the job, may not necessarily be disabled under the old-age and survivors insurance definition of disability. This might be because the impairment, although disabling for the person's usual occupation, cannot be considered disabling for all substantial gainful activity.

This is all in rather sharp contrast to the concepts underlying some of the other disability programs with which the American people have come to be familiar. Industrial disability retirement programs, for example, in their approach to the problem of premature retirement, understandably tend to emphasize aspects of the problem which give the employer primary concern. They must think in terms of disability retirement when the individual, because of his condition, is unable to continue at his regular job or work satisfactorily at any other job available in the company. It is for this reason that our determinations of disability in some cases disagree with those of industrial retirement programs. Similarly, our decisions sometimes differ from those of private insurance, the several types of veterans' programs, workmen's compensation and others.

Administrative Framework

Now, how is the ball set to rolling in an individual case?

When the disabled person (or someone on his behalf) contacts the Social Security Administration district office, he is asked to obtain evidence of the disability and of its severity. Here the attending or reporting physicians give their assistance to him in completing the necessary medical forms, giving data on which a determination may be based. I would like to correct a misconception that seems to have developed in this regard. It is *not* the responsibility of the applicant's doctor to make the determination of disability. It is his responsibility only to supply diagnostic and supporting clinical information on which a disability evaluation team (under the jurisdiction of a State agency) makes the determination.

A few minutes ago I spoke of the fact that State and Territorial agencies are responsible to a large extent for the administration of the old-age and survivors insurance disability program.[4] This provision was included to assure that determinations of disability would be made in an administrative setting closely related to State programs and to the working relationships they have established with the medical profession. The principle is a sound one but it does set up certain administrative problems. You see, the State agencies actually make the disability determinations, subject to review by the Bureau of Old-Age and Survivors Insurance, to assure consistency of understanding and conformity with procedure. The Bureau may reverse a State finding that disability exists but it cannot reverse a finding that *no* disability exists. Such a decision is subject only to appeal by the applicant.

[4] Under the Social Security Amendments of 1954, the Secretary of the Department of Health, Education, and Welfare has entered into agreements with State agencies for the purpose of making determinations of disability. Agreements exist with 56 agencies in 52 jurisdictions. (In 5 jurisdictions, the determinations are made by a public welfare agency which also administers programs of Federal-State aid to needy disabled persons. In 4 jurisdictions, the work of determinations is shared by a vocational rehabilitation and a public welfare agency or a special agency for the rehabilitation of the blind. In all other jurisdictions, the determination of disability is made by the State agency which administers the Federal-State vocational rehabilitation program.)

Therefore, after the claimant has filed his claim and his proofs in a Social Security Administration district office, the case is transferred to a State agency—usually a State vocational rehabilitation agency. The further development of his case from a vocational as well as a medical basis, and the adjudication of disability, is in the hands of an evaluation team of medical and lay personnel. Such further field investigations and medical examinations as may be necessary are carried forward at the initiative of this evaluation team.

Evaluation Guides

All of you know that disability evaluation is a highly complex process. The problem of administration is not so great when the criteria are to be applied by a compact group of evaluators, perhaps centralized in one spot or under uniform administrative direction. The problem becomes more difficult when decisions are made by widely dispersed teams under varying jurisdictions.

In evaluating disability on a mass scale, it has been essential to develop—and to keep refining—a tool which will help to get the job done with greater facility and uniformity. For this purpose, we prepared (with the constructive assistance of the Medical Advisory Committee) evaluation guides, which contain clinical descriptions of over 130 disabling conditions that demonstrate great severity from the point of view of anatomical damage, functional loss, or residuals. In the absence of actual work or other evidence indicating an ability to work, the levels of severity which the guides describe for various conditions can be considered to constitute disability consistent with the statutory definition.

However, I cannot emphasize too strongly that the guides are just *that*, and we do not adjudicate with rigid or mechanical adherence to the clinical descriptions. The guides do not constitute a rating schedule—each case is evaluated on its own merits. The decision whether an individual case comes close to an appropriate level of severity is in all instances, one which requires the professional judgment of the evaluation team. Every State team includes in its membership a medical consultant, often a practicing physician who serves part time as consultant to the State agency.

The determination of disability, while tightly anchored to medical demonstrability, is not exclusively a medical finding. As a practical matter, it is not possible to divorce "disability" from the vocational and personal context in which it is found. There are a group of cases which, when viewed from a medical standpoint, do not permit a presumption that the individual is either clearly in or clearly out. In this so-called "grey area" special attention is given to factors such as the individual's previous education and skills, his age, and his job adaptability. With the assistance of the State vocational rehabilitation agencies, we are attempting, on a case by case basis, to draw conclusions that may permit establishing a second set of guidelines (paralleling the medical guides) which will be applicable to non-medical factors.

Vocational Rehabilitation

While the primary operating mission of the Bureau of Old-Age and Survivors Insurance, in the disability field, is to assure a proper determination of disability so as to provide protection against loss of income or loss of benefit rights, nonetheless, the disability evaluation process is intimately concerned with positive steps to restore impaired individuals to self-help and economic self-reliance.

One of the most significant features in the new social security law is the requirement that all applicants, whether for benefits or the "freeze," be referred promptly to their State vocational rehabilitation services. The vocational rehabilitation agencies will thus know about all these cases. If sufficient appropriations are made available to them, they will be in a position to provide many of these handicapped people with appropriate medical and vocational services which may prevent more serious disability or restore working capacity.

The Bureau of Old-Age and Survivors Insurance has a great interest in the rehabilitation of the disabled. Aside from the social desirability of restoring individuals to self-reliance, it is obviously to the advantage of the disability insurance trust fund that, if at all possible, the disabled person be restored to productive work. In line with these objectives, the law provides that an individual's benefit payments shall be suspended if he refuses without good cause to accept available rehabilitation services under a State plan. On the other hand, if he does undertake rehabilitation, he may continue to receive benefits for a "grace" period of one year, even though working, if his work is pursuant to an approved rehabilitation plan.

A Look Ahead

But the disability program is not only a program of income maintenance or of referral to State agencies; it also has far-reaching implications for other programs. The Bureau has always had a fundamental concern to be of maximum assistance to the people whom it serves. Bureau district offices serve as sources of information about the resources of the community, refer inquiries to the

appropriate agency, and participate with other community groups in planning for more adequate service to the public.

Up to this point, I have not given you an indication of how many decisions of disability we have made to date. Of approximately one-half million applications received since January 1, 1955, over 400,000 have been processed to completion. Over 200,000 of these have been allowed. The balance have been denied, largely because we found their conditions not so severe at the time they stopped work and thereafter as to prevent substantial gainful activity. Nearly one-fifth of all denials, however, are not on vocational and medical grounds, but because of the failure of applicants to satisfy the work requirements in the law, or for other technical reasons.

Many persons with serious handicaps have applied under our program and have had to be denied a freeze or benefits because we find they have sufficient residual capacity to do some kind of gainful work; however, many of them have not been able to find a job outlet for their residual capacities.

In order to make sure that our policies and administrative procedures are pointed in the direction of emphasizing return of disabled to productive work, we will continue to explore with industry, with vocational rehabilitation, the President's Committee on Employment of Physically Handicapped, Special Placement Services of the Bureau of Employment Security, and allied public and private agencies, what we can properly do to help restore the disabled to their former role of contributing members of society.

In this exploration, we are particularly interested in how our claimants get along, particularly those we deny. Are they able to put their remaining skills to work? To what extent are they being absorbed into the competitive labor force? Into sheltered workshops? How many of them, unable to get jobs, exhaust their resources and must fall back on public welfare programs such as Aid to the Permanently and Totally Disabled, Aid to the Blind, and general assistance?

A constructive and imaginative response to the problem seems necessary—a fresh focus of community resources. A real program dilemma may develop over a period of years if we deny a significant proportion of all claimants on the grounds that they have enough residual capacity to engage in substantial gainful activity, and yet, these claimants find that they are rejected by employers as unfit for work.

Will these divergent results be viewed as growing out of general economic circumstances, of unrealistic pre-employment requirements by employers, or of unrealistic concepts and standards in the disability feature of the old-age and survivors insurance program?

Increasingly, industry is making available payments for disabled employees who must retire prematurely. At the same time, industry is also finding new jobs for handicapped workers. We are all becoming aware that we may not be doing either the worker, industry, or the total economy a favor by retiring the "disabled" who can still do something useful. With an increasing public consciousness of the scope and effect of the problem of disability on our Nation's manpower, one of the questions which deserves early attention is: Can the objectives of the industrial plans, and of the community's facilities for rehabilitation and selective placement, and of the public disability programs be brought into relationship, each with the other?

In the procedures we have established, we are consulting closely with the medical profession. We are also working closely with the contracting State agencies, with the Office of Vocational Rehabilitation, and with other constituents of our Department of Health, Education, and Welfare.

We are operating on the principle that the solution chosen to solve our problems should be tested against the following considerations:

1. Is the policy or procedure consistent with the rehabilitation objective and generally in the public interest?
2. Does it contribute to objectivity in evaluation?
3. Does it minimize the possibility of abuses?
4. Is it consistent with good medical relationships and does it minimize the burden on physicians and avoid disturbance of doctor-patient relationship?
5. Is it technically and administratively feasible?

Conclusion

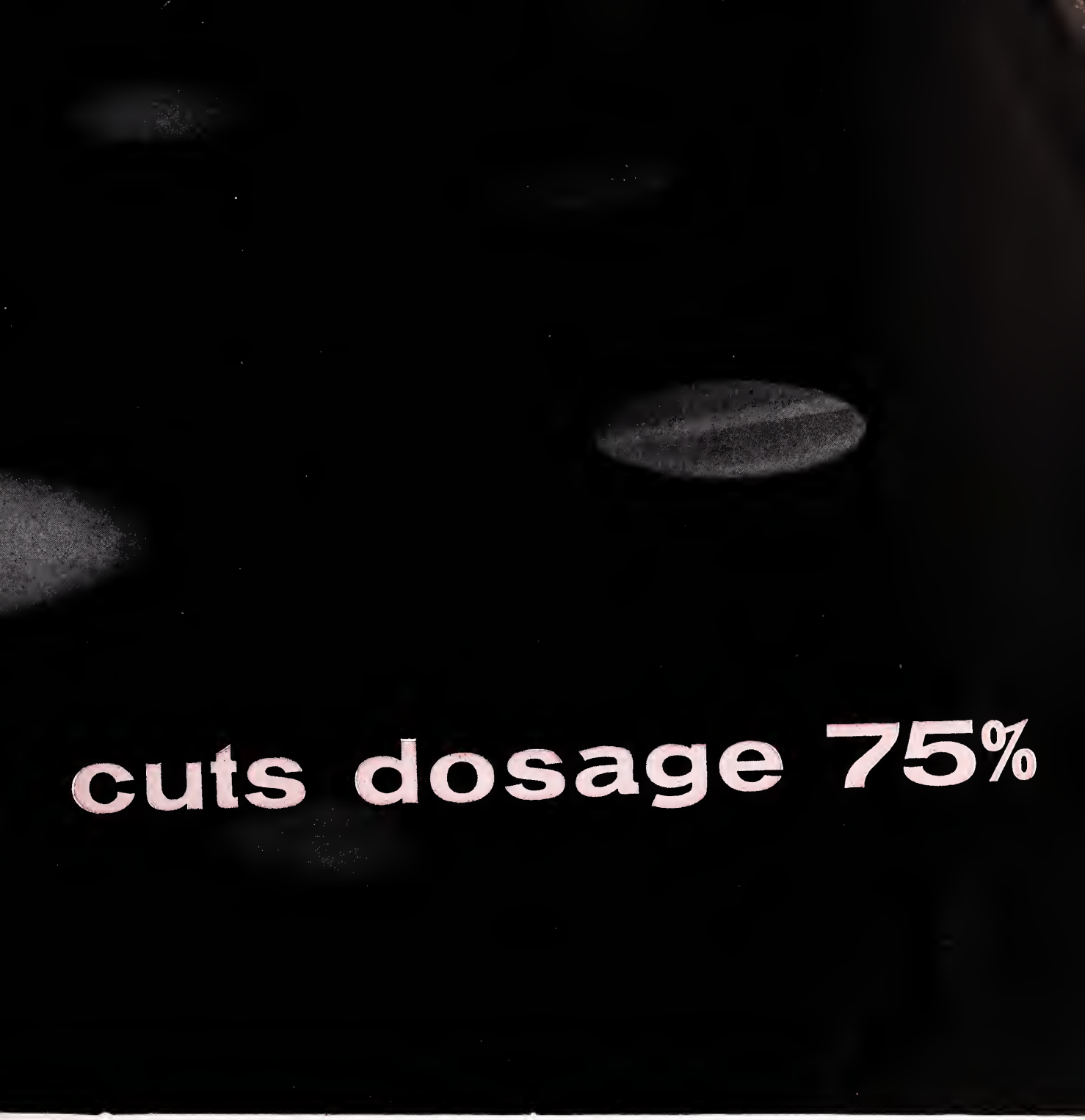
The central function of the old-age and survivors insurance program is to provide its contributors and their families with basic economic protection when need arises as the result of loss of earnings because of retirement in old age, death, or totally incapacitating disability. In a larger context, however, it is the undeveloped work potential of the handicapped that offers hope and promise for the future. In the realization of this promise, I believe that the old-age and survivors insurance disability program, with its emphasis on rehabilitation, will prove to be a positive force.

However, as I said a moment ago, while many of the disabled cannot find job outlets for their residual capacities, many of them do have the potential for rehabilitation and re-employment if, before it is too late, the community as a whole reaches out to assist them. Hopefully, in the years ahead, we can all work toward drawing the common objectives of medicine, management, labor and government into a single pattern of cooperative action.



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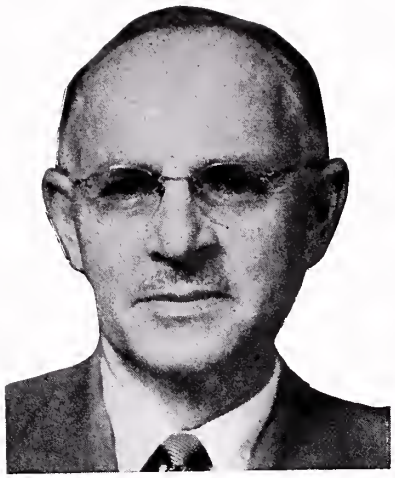
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WEBSTER BOYDEN, M.D.

The President's Page

As this is written, the Medicare Program has been in operation in Hawaii for four months. As expected, the implementation of the Act has not been without a certain amount of friction. The latter has arisen from claims which exceed the negotiated fees, claims that do not readily fall into the items as listed in the Schedule of Allowances, and in the processing of disputed claims. It is believed that with the recent appointment of a Federal Medical Services Committee, to which all claims in which there is disagreement will be forwarded, instances of this nature will in the future be readily and satisfactorily resolved.

I wish also to mention some of the features of the Social Security Amendments of 1936. This new law, which was enacted on August 1, 1956, initiates the payment of Social Security benefits to those workers age 50 or over who are totally and permanently disabled. It is estimated that by July 1, 1957, almost a half a million people will be receiving Social Security benefits fifteen years earlier than they would have under the older law. Although a doctor is required to supply medical *evidence* of disability, he does not *determine* disability. The physician should understand and clearly explain to his patient that the doctor's role in the program is only to make and report the results of his examination. Otherwise he can lose much in public relations, besides putting himself in a difficult and embarrassing spot. The adjudication of disability will be made by a State Agency; but, as in all federal grants programs, control and final decision rest with the Federal Government. Under the law the applicant is required to furnish proof of his disability and is responsible for any costs involved in obtaining his medical report. If as a result of the medical report the patient's application for disability is refused, he will in many cases blame his physician. However, the law states: "The patient's doctor is never asked to certify that his patient is or is not permanently or totally disabled; he is asked to provide the evaluation team (State Agency) with clinical information from which the team can draw its own conclusion."

W. Boyden

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[EDITORIALS]

Hawaii Mental Health Association

The prevention of mental illness and the alleviation of suffering which it causes are praiseworthy aims in any community, and they cannot be fully accomplished by the medical profession, even with the professional help of psychologists, nurses, social service workers, and so forth. Community effort is required, and it has not been lacking in Hawaii.

This effort was first formally expressed in the foundation, in 1942, of the Hawaii Mental Health Association, the only health agency under the aegis of the Community Chest.

The program and aims of the Association were recently summarized by a special committee* under the chairmanship of Mr. Robert Craig, as follows:

1. Inquiry into mental health needs through the Community Planning Committee for Mental Health, sponsored jointly with the Oahu Health Council, and through representation on advisory boards of other agencies, as well as by initiation of appropriate studies and discussions.
2. Legislative program.
3. Lay education program (public programs, workshops, seminars, pamphlets, etc.)
4. Making mental health and psychiatric information and referral service available to individuals.

Plans for further implementation of this program included publication of a directory of mental health resources; development of special educational projects; promoting mental health career interest in high school students; and maintenance of liaison with the Territorial Hospital Auxiliary.

Future plans, not possible with present financial resources, included: fostering research into significant contributing causes of mental illness in Hawaii; fostering training of ancillary professional personnel; investigating the problem of rehabilitation of discharged mental patients; special studies of prevention of mental illness in relation to industry, and in relation to children; and others.

The 1957 membership drive of the Mental Health Association is just drawing to a close, but it is not too late. Perhaps you're too busy to participate actively in the Association's deliberations. Surely, though, you aren't too busy to lend them your moral and financial support. This they need; this they deserve. Like all Chest agencies, they are required to provide a part of their financing outside the Chest, and this they do through membership dues. Send them your check, for what you feel you can afford, and become a member today. It is an investment in the future of your community!

* Committee members: J. Ralph Brown, Herbert Weaver, Maxine Sandison, and Robert Craig, Chairman.

Bureau of Medical Economics

Group Disability Insurance

In the last issue of the JOURNAL, we wrote an article on the Honolulu County Medical Society's Group Disability Insurance.

Meanwhile, the Public Service Committee has looked into this plan. They found that the trend of participation was endangering the continuation of the plan and that a cancellation would come as a particular hardship to those who are presently covered, but who because of age or physical condition may find it difficult or impossible to secure other protection. They found that no publicity or follow-up has taken place since the plan's inception several years back.

The committee sat down with representatives from the insurance carrier and suggestions were made from both sides on several steps which, in their opinion, would strengthen the plan and make it even more valuable and attractive. Many hours were spent and finally the committee decided that the plan should offer Catastrophic Hospital Benefits for the member and, at his option, his family; should have a change made in the premium structure, so that younger doctors could afford the annual premium; and it should include increased weekly indemnity benefits.

The Board of Governors, on the recommendation of the Public Service Committee, has accepted and endorsed a revised Honolulu County Medical Society Group Disability Plan which will be made available to members. This plan will offer Loss of Income Disability Protection and, as an optional addition, basic Hospital Coverage or Catastrophic Hospital Protection. This plan is underwritten by the United States Life Insurance Company and administered by Brainard & Black, Ltd.

The revised Honolulu County Disability Plan will provide weekly indemnities of $50, $75 or $100 a week plus Accidental Death and Dismemberment indemnities up to $5,000. The premiums on this revised plan will be lower than those charged on the original plan which was adopted by the Society in 1950 for all members under age 60.

In addition there will be a $7.00 a day Hospital Plan available as an optional benefit which may be continued by members who now have this protection. New members may add it to their Disability Plan.

For the first time, a Catastrophic Hospital Plan is available to the membership of the Society *and their dependents*. This plan provides $5,000 for all hospital expenses for each person, and includes 75% of nurses' fees in the hospital, subject to a $500 deductible clause. This plan is particularly attractive to members of the Society who are more often concerned with the increasing expense of hospital care rather than the expense of medical care.

A new open enrollment period during June and July will be set aside whereby all members will be entitled to enroll in the plans WITHOUT showing EVIDENCE OF INSURABILITY, provided:

(a) Under the Basic Disability Plan those members not now insured will be eligible if at least 50% of those not now covered enroll during this period.
(b) Under the Catastrophic Hospital Plan, if at least 75% of the eligible members enroll during this period.
(c) All members presently insured under the plan will be entitled to continue with the same amount of weekly indemnity as they now have without showing evidence of insurability.

This revised program provides better and more attractive coverage for all members and at lower rates for the majority of the members.

The key to success of any group insurance plan is proper participation in order that the law of averages is given an opportunity to work. All members will receive descriptive brochures and information in the mail and a representative of the administrator will be available during the open enrollment period to answer questions and to assist in enrollment.

Participation on the part of the majority of the membership will make it possible for those members who might ordinarily be unable to obtain protection, due to uninsurability, to take advantage of these plans. Only the cooperation of the membership can make the Honolulu County Medical Society Group Disability Plan successful.

R. M. KENNEDY
Executive Secretary

This is What's New!

At Harvard, seven **chronic alcoholics with cirrhosis** received as part of their treatment 3 to 4 ounces of 95 per cent **ethyl alcohol** daily. This, along with an adequate diet, appeared to hasten rather than retard their **clinical improvement.** The most noteworthy effect of the alcohol was increased euphoria with heightened appetite. The alcohol had no adverse effect on the liver, as measured by liver biopsies or liver function tests. The authors indicate that alcohol may have a place in the treatment of alcoholics with cirrhosis. (*The Lancet* [Feb. 16] 1957.)

* * *

Spinach chloroplasts have been coming with **cytochrome C photo-oxidase** all the time, only no one ever knew it until now. This light enzyme converts cytochrome C, FE 2 plus, to cytochrome C, FE 3 plus, by oxidation. If this knowledge doesn't do the trick, don't eat it! (*Science* [Feb. 22] 1957.)

* * *

If your nervous patient is nervous about taking tranquilizers because he "may lose 40 per cent of my mind like the newspapers say," science has found a counter-gambit. "Don't be nervous about taking your tranquilizer; if you happen to have leukemia, your medication will hold this in check for a while." **Reserpine** was second only to 6 mercapto-purin and A-methopterin in increasing survival time of **leukemic mice.** (*Science* [Jan. 25] 1957.)

* * *

The treatment of **barbiturate poisoning,** according to Scandinavian and more recently American workers, should be physiological rather than pharmacological and directed towards circulatory management, respiratory exchange and avoidance of complications of coma, such as pneumonia, and so forth. This is accomplished by the use of vasopressor agents, such as **ephedrine** or **levarterenol,** artificial respiration, including the tank respirator, and maintenance of an adequate airway and **antibiotics.** Analeptics, such as picrotoxin, megimide and electroshock, were felt to be of very limited value. (*J.A.M.A.* [Mar. 9] 1957.)

* * *

A Boston urologist has found salicylates excellent for **preventing recurrent kidney stones.** Salicylates stimulate the production of glucuronic acid which increases the solubility of calcium in the urine. Salicylates were administered as **Aspirin** or as **salicylamide.** Both were given in a dose of 2 grams a day. This treatment should not be used for uremic patients because of the hazard of salicylate retention. (*Med. News* [Mar. 25] 1957.)

* * *

Phenylbutazone (Butazolidin) is similar to cortisone in its antirheumatic, ulcerogenic and uricosuric action. Both drugs may also cause sodium retention. It has been known for some while that cortisone **depresses radioactive iodine uptake** by the thyroid. **Butazolidin** parallels cortisone in this respect also. The inhibition of thyroid uptake of I^{131}, however, is abolished by the administration of thyroid-stimulating hormone. The most important difference here, however, is the **temporary** action of the phenylbutazone despite continued therapy, in contrast to the cortisone inhibition of I^{131} uptake, which persists as long as the cortisone is administered. (*J. Clin. Endocrinol.* [Mar.] 1957.)

* * *

The doctor may carry the cause of his own disease in his medicine bag, warns Dr. Fox of Michigan. Each year, as many **physicians** turn into **narcotic addicts** as graduate from one of the country's medical schools. Basic emotional disorders complicated by alcoholism, fatigue or pain usually are responsible for the addiction. (*J. Michigan State Med. Soc.* [Feb.] 1957.)

FRED I. GILBERT, JR., M.D.

HMSA—Its Place in the Community

Professional Relations Conference

R. B. FAUS, M.D., *Medical Director*

The 1957 Professional Relations Conference held in Chicago last February was productive of some thoughts that merit sober reflection.

Dr. Robert L. Novy of Michigan, President of the Blue Shield Medical Care Plans, spoke on the vital role of professional relations. The problem now facing us is the lagging interest of doctors. He likened the Blue Shield to the flag—blue for loyalty and steadfastness of purpose with the Aesculapian staff signifying a medical sponsored plan offering a protective defensive type of service to its members.

He described the doctor as an odd creature by reason of his training and experience. He wants freedom for himself and his patient. He demands the right to make his own decision as to the value of his services. He is interested in what fellow physicians and the community think of him and conforms to the idealism of his community. The responsibility of professional relations people is to create a better understanding of Blue Shield among doctors. A new generation of doctors is now coming into practice having completed military service and residency requirements. They are often complacent because they have not been indoctrinated with the principles of Blue Shield. They forget the significance of the Blue Shield and the Aesculapian staff and when no threat to their security seems imminent, lethargy develops.

Now more than ever during the attack of competitive plans their morale must be kept up as nothing but Blue Shield can do. It is their only weapon of defense.

Competitive plans are in business for profit. Oregon at first let commercial firms handle the insurance, and what happened? Tonsillectomies were set at $10 and office calls at 50¢. Now the doctors prepare the fee schedule and offer their own sponsored plan which they support wholeheartedly; in fact, each doctor pays $100 to become a participating physician in Tacoma.

What are the functions and purpose of Blue Shield?

1. Prepayment of services of professional people.
2. Make available prepaid health insurance at lowest possible cost.
3. Provide medical care to American people at a cost they can afford.
4. The profession provides the service and sets the fees. Blue Shield collects the dues and pays the bills according to agreed schedule, and continues the acquisition of new members.

Why should Blue Shield need new members? The answer is that doctors have to have patients. They cannot survive on just those currently ill. Complacency is defeatism. The larger the membership, the more money for service benefits. Blue Shield is the economic arm of the medical profession.

Why should you be a participating physician? It is a democratic principle. Your survival is at stake. You have a voice in HMSA policy, benefits, and patterns. The time, talent, and skill of physicians make HMSA better than any other plan.

In other plans motivated by profit, the physician has no voice in fees or benefits.

The most important thing now is for the profession to protect its plan that it may remain competitive with closed panel and commercial plans.

Labor is demanding its own plan, hiring its own physicians, and offering diagnostic and outpatient services as well as surgery and hospitalization at employers' expense or the taxpayer or government expense.

Panel plans succeed because physicians are employed to make the plan succeed. The Medical Director sees that plan policy is carried out by the employed physicians. He hires and fires at will. It is corporate practice of medicine. Co-insurance factors and sale of drugs make the operation a profitable one and abuses remain at a minimum.

It behooves every doctor now to become familiar with the HMSA plans in every detail and then make a comparison with panel plans and commercial plans. Only with such understanding and close cooperation, confidence and support to the fullest extent in the plan that you have something to say about, will the private practice of medicine and surgery survive in Hawaii.

Perhaps It's Your Nerves

Mental Health Programs—1957

For the first time in the history of the United States, fewer patients were in public mental hospitals at the end of the year than at the beginning. The statistics at the end of 1956 showed a decrease of 7,000 resident patients below the figure for 1955. It is further interesting to note that 1956 was also the year of the highest admissions to mental hospitals, with 8,000 more patients being admitted in 1956 than in 1955.

Inspired by these figures, the National Mental Health Committee conducted a study of all state mental health programs.

Most states reported agreement on the need for a balanced treatment program and the Committee felt that the recent increases in state legislative appropriations have "finally achieved accumulative force needed to reverse the seemingly inevitable rise in mental hospital populations."

In addition to this, there were other areas of agreement from most states. (1) Patients are now being treated rather than simply maintained; (2) The impact of the so-called tranquilizer drugs has created a need for more medical personnel and recreational and occupational facilities; (3) Research has to be accelerated; (4) Childrens' and Outpatient Units must be increased.

Discharge rates for most hospitals were increased, and the better-staffed hospitals were discharging between 65 and 80 per cent of all first admissions. The Committee also found that more professional people are going into public mental health work.

Training and research are getting increased emphasis in the field of mental health. General medical practitioners in some areas are receiving additional training so that they can not only help with their own patients' minor psychiatric problems, but also aid in the state mental hospital system, community mental health clinics, and aftercare of discharged patients from these agencies.

Emphasis on outpatient treatment for psychiatric disorders is strong. Convalescent services of mental hospitals are being augmented with excellent results. Strengthening of community mental health clinics is of great value in prevention of extreme psychiatric handicaps. Private practitioners, as well as state clinic and hospital physicians, are giving their time to community clinic services.

Psychiatric services in general hospitals are aiding in the treatment of acute transient psychotic disorders, psychosomatic conditions, and psychoneurotic states.

Greater sums are being appropriated for psychiatric research, including a strong emphasis on the physiological side of mental disease.

States are finding that it is necessary for them to supply training facilities so that local people can be trained to enter the mental health field and ease the serious shortage. This is certainly true in Hawaii, where the lack of a medical school necessitates mainland recruitment in many cases. Recruitment of local people is highly desirable because of their familiarity with the islands and the cultural setting in which our people live.

There is a national trend (which includes the United States Public Health Service) toward developing more specific drugs in the treatment of certain kinds of mental illness. The mass of work on the tranquilizing drugs has led to the creation of a "clearing house" at the Federal level so that research can be coordinated in this area. Similar to this, is the work done by the Interstate Clearing House on Mental Health of the Council of State Governments which is working toward regional cooperation in psychiatric research and training.

In every community, there are many individuals and agencies involved in the care of people with personality disorders. Private physicians and private hospitals participate in these matters from the family physician level to the general hospital psychiatric unit level. Community agencies, such as Family Service Societies, visiting nurses, mental health associations, churches, courts, and other welfare, educational and health agencies are very much involved in the mental health program. Facilities such as psychiatric hospitals, sanitariums, and psychiatric outpatient clinics in combination with schools for the care of delinquent children, epileptic and mentally defective persons have a major role in the treatment and prevention program.

State departments of mental health, public health, welfare, education and corrections are supplemented by additional state programs on voca-

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The Honolulu County Medical Library

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Recent Acquisitions

Cancer

Cameron, C. S. *The truth about cancer.* c1956. (gift Hawaii Cancer Society)

Mohs, F. E. *Chemosurgery in cancer, gangrene and infections.* c1956. (gift of publisher)

Cardiology and Hematology

Bessis, Marcel *Cytology of the blood and blood-forming organs.* c1956. (gift of publisher)

Gross, R. E. *Surgical treatment for abnormalities of the heart and great vessels.* c1947. (gift of Dr. Waite)

Rushmer, R. F. *Cardiac diagnosis.* c1955. (gift of publisher)

Ruskin, Arthur *Classics in arterial hypertension.* c1956. (gift of publisher)

Wintrobe, M. M. *Clinical hematology.* 4th ed. rev. c1956.

Drugs

Gross, E. G. *Clinical analgetics.* c1955. (gift of publisher)

Lepper, M. H. *Aureomycin (chlortetracycline).* c1956. (gift of publisher)

Infectious Diseases

Flippin, H. F. *Antimicrobial therapy in medical practice.* c1955. (gift of publisher)

Wolstenholme, G. E. W., ed. *Ciba Foundation symposium on the nature of viruses.* 1957. (gift of Ciba Foundation)

Laboratory Diagnosis

Gradwohl, R. B. H. *Clinical laboratory methods and diagnosis.* 2 vols. 5th ed. c1956. (gift of publisher)

Wolstenholme, G. E. W., ed. *Ciba Foundation symposium on paper electrophoresis.* 1956. (gift of publisher)

Medicine

A.M.A. Council on Scientific Assembly *A.M.A. scientific exhibits, 1956.* (gift of publisher)

Gregg, Alan *Challenges to contemporary medicine.* c1956. (gift of publisher)

Meakins, J. C., ed. *The practice of medicine.* 6th ed. c1956. (gift of publisher)

Physicians desk reference. 11th ed. 1956. (gift of Squibb)

Neurology and Psychiatry

Bauer, Julius *The person behind the disease.* c1956. (gift of publisher)

Bergler, Edmund *The superego.* c1952. (gift of Dr. Doolittle)

Courville, C. B. *Commotio cerebri.* c1953. (gift of Dr. Burt O. Wade)

Courville, C. B. *Pathology of the central nervous system.* 3rd ed. c1950. (gift of Dr. Burt O. Wade)

Ewalt, J. R. *Mental health administration.* c1956. (gift of publisher)

Hunt, W. A. *The clinical psychologist.* c1956. (gift of publisher)

Selye, Hans *The stress of life.* c1956. (gift of publisher)

Wallen, R. W. *Clinical psychology.* c1956. (gift of publisher)

Wolff, Werner *Diagrams of the unconscious.* c1948. (gift of Dr. Burt O. Wade)

Obstetrics

Atlee, H. B. *Natural childbirth.* c1956. (gift of publisher)

Eastman, N. J. *Williams obstetrics.* 11th ed. c1956. (gift of publisher)

Ophthalmology

Cogan, D. G. *Neurology of the ocular muscles.* 2nd ed. c1956. (gift of publisher)

Orthopedics

Hackett, A. S. *Joint ligament relaxation treated by fibro-osseous proliferation.* c1956. (gift of publisher)

Quigley, T. B. *Plaster of Paris technique in the treatment of fractures and other injuries.* c1945. (gift of Dr. Waite)

Pediatrics

Foote, E. J. *Six children.* c1956. (gift of publisher)

Good, R. A., ed. *Essays on pediatrics in honor of Irvine McQuarrie.* (gift of Dr. Kometani)

Leider, Morris *Practical pediatric dermatology.* c1956. (gift of publisher)

Poliomyelitis

Bower, A. G., ed. *Diagnosis and treatment of the acute phase of poliomyelitis.* c1954.

Faber, H. K. *The pathogenesis of poliomyelitis.* c1955. (gift of publisher)

Radiation

Cronkite, E. P., ed. *Some effects of ionizing radiation on human beings.* 1956. (gift of Atomic Energy Commission)

Oughterson, A. W., ed. *Medical effects of the atomic bomb in Japan.* c1956. (gift of publisher)

Wolstenholme, G. E. W., ed. *Ciba Foundation symposium on ionizing radiations and cell metabolism.* 1956. (gift of Ciba Foundation)

Surgery

Burks, J. W., Jr. *Wire brush surgery.* c1956. (gift of publisher)

Pye, Walter *Elementary bandaging and surgical dressing.* 7th ed. 1896.

St. Mary's Hospital *Operating room technic.* 5th ed. c1957. (from Nurses' Association)

Shefts, L. M. *The initial management of thoracic and thoraco-abdominal trauma.* c1956. (gift of publisher)

Tripler Army Hospital *Surgery in acute trauma, a symposium.* 1957. (gift of Tripler Army Hospital)

Miscellaneous

Block, R. J. *Amino acid handbook.* c1956. (gift of publisher)

Brown, Lawrason *Edward Livingston Trudeau.* 1953. (gift of Dr. Doolittle)

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Book Reviews

The Stress of Life.

By Hans Selye, M.D., 324 pp., Price $5.95, McGraw-Hill Book Company, Inc., 1956.

This volume, although written for laymen, should prove invaluable for medical men. It presents the stress concept and the experimental work done with the general adaptation syndrome in a manner which is very enlightening and inspiring. An over-all philosophical concept of this kind which ties together so many medical facts should prove invaluable to medical men. There is a personal quality in the writing which intensifies the interest and makes the concept more palatable and easier to digest. I would strongly recommend that this book be read by all medical men as an introduction to the more technical and voluminous literature on the stress concept.

J. Robert Jacobson, M.D.

Antimicrobial Therapy in Medical Practice.

By Harrison F. Flippin, M.D., and George M. Eisenberg, D.Sc., 284 pp., Price $5.00, F. A. Davis Co., 1955.

This is a very terse but informative volume regarding antimicrobial adjacents as far as practical aspects are concerned. Information is readily accessible especially since the index is quite complete. The information is up to date. The book uses tables effectively. Physically, the binding is good and the print is large and easily read. This is one of the most valuable references printed regarding antimicrobial therapy and is almost a must for every practicing physician.

W. Harold Civin, M.D.

Neurology of the Ocular Muscles.

By David G. Cogan, M.D., 296 pp., illus., Price $8.50, Charles C. Thomas, 1956.

The second edition of this excellent monograph has much to offer to the specialties of ophthalmology and neurology.

Beginning with a short section on the anatomy and action of the ocular muscles, the author develops his treatise into the neuro-physiologic and clinical aspects of disturbances in ocular motility.

The correlation of newer concepts of neuro-anatomy and neuro-physiology with the clinical aspects of neuro-ophthalmologic problems is commendable. An example is the section dealing with internuclear ophthalmoplegia and its relationship to multiple sclerosis.

Also, in contrast to the more usual encyclopedic type approach by disease entities to problems of this category, the material is presented in the light of their objective manifestations, followed by their clinical neuro-anatomic and neuro-physiologic inter-relationships.

A valuable feature is the section at the end of each chapter which summarizes the clinical application of neuro-anatomic and neuro-physiologic concepts to problems of disturbances in ocular motility.

Adequate case material with illustrations from the clinical experiences of the author, along with an extensive bibliography, serve to make this monograph a worthy contribution.

Vernon K. S. Jim, M.D.

The Person Behind the Disease.

By Julius Bauer, M.D., F.A.C.P., 136 pp., Grune & Stratton, 1956.

In his preface, Dr. Bauer states that the object of the book is to elaborate the principles of a holistic concept of medicine and the theme throughout the whole book is that the patient must be considered as an entire person, both mind and body, rather than as an individual who to some specialist may harbor some involved set of symptoms pertaining and limited to a well-known syndrome or disease.

Psychosomatic medicine is a part of this concept. To this, Dr. Bauer adds with strong emphasis the factor of heredity and disease. Throughout the years the pendulum has swung many times between the emphasis played by heredity versus environment and constitutional inadequacies and illness. In this book, the swing is very definitely to the side of heredity. Target organs and constitutional inadequacies are reviewed and many examples of deviation to physiological patterns cited. For example, he points out that the male natives of India excrete about only one-half of the total amount of 17-ketosteroids that healthy male Europeans do, and this without any evidence of adrenocortical deficiency.

Dr. Bauer feels that the tendency in medicine today is to go further and further away from the full understanding of the patient as an individual, that with any attempts at specialization, marked advances in medicine, more and more time is being required to obtain technical knowledge at the expense of humanities. A fact which is well known to most general practitioners, that the patient must be treated in mind, body and soul, is often lost sight of by the highly trained specialist dealing in a very narrow field. Certainly today this problem is still being fought over. There is a tendency among some colleges to delete requirements for medical school and shorten the time of entrance into medical school so that more and more time may be spent with the purely technical skills of medicine.

L. Clagett Beck, M.D.

Practical Pediatric Dermatology.

By Morris Leider, M.D., 433 pp., illus., Price $10.50, C. V. Mosby Co., 1956.

This new work on a subject much in need of wide attention comes close to the mark but does not completely fill the requirements. It has the usual basic science portion common to texts on dermatology with rather good tables of the frequency and location of dermatoses and a very clear discussion of anatomy, physical examination, and laboratory procedures. The pictures are generally good and the organization of the contents is along conventional etiological lines. The extended dissertations on atopic eczema, acne vulgaris, and other problems of pediatric management are illuminating and would serve for all to read. In general this book seems intended for the man who has gone through school without learning any dermatology and later finds himself in a position of necessity.

The style of writing is scholarly but with informal breaks which show the influence of Sulzberger, e.g. a

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In Memoriam -- Doctors of Hawaii -- VIII

This is the eighth installment of In Memoriam —Doctors of Hawaii.

Susumu Yamamoto

Susumu Yamamoto was born on December 14, 1866, in Saga City, Fukuoka Prefecture, Japan. His father, Dr. Shozo Yamamoto, served as court physician to Lord Nabeshima of Saga.

Following his father's profession, he pursued the study of medicine at Kagoshima Prefectural Medical College. He was graduated from that institution on March 30, 1886.

From 1889 to 1890 he did graduate work at Tokyo Imperial University Medical School.

On the recommendation of Foreign Minister Shigenobu Okuma, Dr. Yamamoto came to Hawaii as physician to the Bureau of Immigration. He worked in Hilo, Hawaii. In 1900 he returned to Japan to do postgraduate work in obstetrics and gynecology at the Tokyo Imperial University.

Returning to Hilo in 1909, he practiced there until 1919 when he moved to Haleiwa, Oahu, where he practiced until 1932.

Dr. Yamamoto's wife was Ai Setoyama of Japan. They had two sons, Chito and Haruka. Chito became a physician and practiced in Haleiwa for two years. They also had three daughters; Shizu, Hiro, and Kimi.

Dr. Yamamoto returned to Japan and died on December 22, 1944, in Kobe, at the age of 78.

Iga Mori

Iga Mori was born in Ishikawa, Japan, on February 11, 1864. He was the son of Yuma and Take (Goto) Oguri.



DR. MORI

He was educated at the Naval Medical College in Japan, graduating in 1887. He also attended the Cooper Medical College at Stanford University, graduating in 1891. Postgraduate courses followed at the University Hospital, London, in 1898. Further studies were pursued at the Postgraduate Medical School in New York in 1904.

Dr. Mori first came to the Islands in 1890 as physician for the Bureau of Immigration of the Kingdom of Hawaii.

Returning to Japan four years later, he became chief surgeon for the First Corps of the Japanese Red Cross in the Chinese-Japanese war of 1894 and 1895. He returned to Hawaii in 1899 to establish permanent residence.

Dr. Mori and Yae Nakagawa were married in Tokyo on September 17, 1888. The Moris had one son, Motokazu, who is at present a practicing physician in Honolulu. His grandson, Dr. Victor M. Mori, is pursuing the medical profession and will make three generations of Doctors Mori possible. In 1940 the Moris celebrated their golden wedding anniversary.

Being one of the medical pioneers in Hawaii, Dr. Mori was interested in many phases of community life. He was a member of the Hawaii Territorial Medical Association; Hawaii Council, Institute of Pacific Relations; Japanese Benevolent Society of Hawaii; Honolulu Y.M.C.A.; American Red Cross; Hawaii Evangelical Association; Hawaii Historical Society; Honolulu Art Society; and the Pan Pacific Union.

Dr. Mori died on May 12, 1951, in Honolulu, at the age of 87.

Donald McLennan

Donald McLennan was born in Baddeck, Cape Breton Island, Nova Scotia, Canada. He came to Hawaii in 1891 and lived here until his death.

Dr. McLennan was married and the father of one daughter. He was a charter member of the Court of Camoes No. 8810, Ancient Order of Foresters. Representing the local order, he was the first delegate to the subsidiary high court on the Pacific Coast. For many years Dr. McLennan was physician of the Camoes, offering his services free of charge. He resigned in 1915 when he made a trip to the mainland, where he remained for some months.

On July 31, 1916, Dr. McLennan died in Honolulu. He was about 68 years of age.

Jyukichi Uchida

Jyukichi Uchida was born on March 25, 1868, in Ishikawa Prefecture, Kanazawa City, Japan. He was the son of Yasohei and Nobu Takakuwa. He received his M.D. degree from the Tokyo Imperial University School of Medicine in 1887.

He came to Hawaii for the first time in 1891 and practiced on Kukui Street. In 1899, due to illness, Dr. Uchida returned to Japan and, while convalescing, he spent some time at Dr. Kitasato's Epidemic Disease Laboratory in Tokyo. Coming back to Honolulu in 1900, he reopened his office on Vineyard Street.

In 1908 Dr. Uchida returned to Japan and went on a study tour with Dr. Kitasato to Germany and the United States. He returned to Hawaii after the tour and practiced on Nuuanu Avenue.

In 1922 he turned his practice over to Dr. Kinji Uchida and went to Japan, where he later married Miss Tome Kanbayashi. They had no children except an adopted son, Kinji.

While in Honolulu Dr. Uchida was president of Japanese Hospital, of which he was one of the founders. He was also one of the founders of the Japanese Medical Society. He was a well read man, and his literary ability extended to Chinese poetry, which he wrote under the pen name of Shungai.

Upon his return to Japan, he took a position at Dr. Kitasato's Epidemic Disease Laboratory in 1928. He was also an inspector at Moji Harbor in Japan.

Dr. Uchida died on February 23, 1933, in Tokyo, shortly before his 65th birthday.

Charles Bryant Cooper

Charles Bryant Cooper was born November 19, 1864, at Babylon, New York, the son of the Rev. Charles White and Frances (Duyckynck) Cooper. He was of the same branch of the family as Peter Cooper, philanthropist and founder of the Cooper Institute, New York, and James Fenimore Cooper, the novelist.



DR. COOPER

Charles was educated at Wallkill Academy, Middleton, New York, and Williston Seminary, Easthampton, Massachusetts. His medical degree was received from Washington University, St. Louis, Missouri, in 1889.

Dr. Cooper began his practice in Butte, Montana, but when his health failed he came to Honolulu in search of a change of climate. He adopted Honolulu as his home in 1891 and became a prominent figure in the making of Hawaiian history.

In 1893 Dr. Cooper became police and prison surgeon for the government of Hawaii and was commissioned regimental surgeon in December of the same year.

He participated in the spectacular search for lepers on the island of Kauai in July, 1893. The lepers were resisting removal to the colony on Molokai, and in rounding them up three members of the military party were killed.

From 1894 to 1904 Dr. Cooper was attending physician and consulting surgeon at The Queen's Hospital.

Dr. Cooper married Katherine Christie McGrew, the daughter of Dr. John S. McGrew, in Honolulu, on March 24, 1897. They had three children, Charles Bryant, Jr., John McGrew, and Frances D., now Mrs. Gerald H. Wood.

Following annexation, Dr. Cooper became a member of the Territorial Board of Health in 1900. From 1904 to 1919 he served as Commissioner of Public Health, as a member of the Board of Medical Examiners, and as chairman of the Board of Industrial Schools. In the same period he was chief surgeon for the Oahu Railway and Land Company and a member of the Insanity Commission.

Dr. Cooper had much military experience. He served the provisional government as regimental surgeon and later performed the same duty for the Republic from 1895 to 1898. After annexation he was commissioned surgeon general of the National Guard of Hawaii with the rank of lieutenant colonel. In 1912 he received military training in the field service school for medical officers at Fort Leavenworth, Kansas. He resigned in 1917 to accept a commission as captain in the army, rising to the rank of lieutenant colonel in 1918. He was honorably discharged from the army July 31, 1919.

In 1922 he served under President Harding, while on a year's vacation in Europe, as a "dollar a year man" with the Veterans' Bureau. He was present and represented the Veterans' Bureau in Coblentz, Germany, when the American troops moved out in 1922, turning over the occupied territory to the French.

Dr. Cooper died November 11, 1940, at the family home at Aiea. He was within a few days of his 76th birthday.

He was a member of the Board of Regents of the University of Hawaii, a Fellow of the American Medical Association, a member and president in 1899 of the Hawaiian Territorial Medical Society, and a member of the Association of Pacific Coast Railroad Surgeons. He was a Shriner, past potentate of Aloha Temple, first exalted ruler of Honolulu Lodge No. 616 of the Elks, member and former president of the Pacific Club, and a member of the University, Rotary, Ad, and Oahu Country clubs.

Henri Goulden McGrew

Henri Goulden McGrew was born April 10, 1863, in New York City, coming to the Islands with his parents when he was quite young. He was the adopted son of Dr. J. S. McGrew, having been the son of Mrs. McGrew by a former marriage.

He attended Mr. Atkinson's school and Punahou College. He then entered Mr. Brewster's College in San Mateo, California. With his mother he went to Europe and for two years studied in Brussels, Belgium. Returning to the United States, he studied medicine with Dr. Brodie in Detroit and graduated from the Medical College in Detroit. This was followed by postgraduate courses in the College of Physicians and Surgeons in New York.

Dr. McGrew returned to Honolulu and practiced for two years with his father. After his first two years in practice the young doctor returned to Paris and spent five years in the University of Paris and in hospitals.

On his return again to Honolulu he intended to specialize in diseases of the eye and ear but entered into general practice. He was in charge of the Dispensary for several years.

Overwork generally undermined his health, and, in hope of improvement, he moved to California about 1892. However, finding no improvement in his health, he returned to Honolulu.

Dr. McGrew was married and had one child.

On October 22, 1894, Dr. McGrew died in Honolulu at the age of 31.

Sanzaburo Kobayashi

Sanzaburo Kobayashi was born in October, 1863, in Katogori, Harima, Japan.

In 1889 he entered Cooper Medical School where he showed special interest in surgery. He practiced in San Francisco for a few years before coming to Hawaii in 1893.

Arriving in Honolulu, he began his practice on Liliha Street. He established his own hospital there, and this was the forerunner of the present Kuakini Hospital. He maintained a charity clinic for the needy at this hospital.

Dr. Kobayashi did much traveling. He went abroad twice to England and Germany and continued his study of surgery. In November, 1902, he returned to Japan, then on to Hong Kong and Canton, China, to practice medicine. He became ill and returned to Japan where he became a zealous Buddhist follower. In 1903 he came back to Hawaii and was appointed director of the Japanese Hospital. He resided in Wailuku, Maui, for some time.

Dr. Kobayashi married Miss Nobuko Shimura of Tokyo and remained in Hawaii until September, 1908.

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County Society Reports

Maui

The regular meeting of the Maui County Medical Society was held at Kula Sanatorium on January 15, 1957.

Members present for dinner were: Doctors Fleming, Underwood, Kashiwa, Ferkany, Tompkins, Cole, Ohata, Rockett, Butler, Iaconetti, Moran, Kanda, Wong, Sanders, Izumi, Patterson, H. Kushi, Burden, McArthur, Tong, Shimokawa, Tofukuji.

Guests present were: Doctors Good, Reichert, Bernstein, Quisenberry, and Mr. Lloyd Eckmann.

A letter from Dr. Kemp of the Territorial Board of Health in reference to the Coroner's Physician for Maui was read. A motion was made by Dr. Patterson, seconded by Dr. Ferkany, to refer the matter to the Legislative Committee of the Maui County Medical Society and that they propose to the legislators that Dr. Moran be appointed Coroner's Physician for Maui and a system for the care of medical indigents be set up along the lines the County Medical Society had worked out.

Dr. Ferkany added an amendment that Dr. Moran be placed on a fee-for-service basis. Seconded by Dr. Iaconetti.

The Maui County Medical Society Woman's Auxiliary presented two volumes of "In Memoriam, Doctors of Hawaii" to the Maui County Medical Society.

Dr. Ferkany spoke on the use of Dionisil in bronchography. He presented x-ray pictures with the use of Dionisil.

Dr. Tompkins gave a short resume of the activities at the Kula Sanatorium that he had presented to the Territorial Legislature on an earlier date. After his talk a motion was made by Dr. McArthur, seconded by Dr. Sanders, that the Maui County Medical Society go on record recommending that arrangements be made to permit the care of chronic chest conditions as well as TB cases at the Kula Sanatorium. Motion carried unanimously. Dr. Quisenberry showed a movie on bronchogenic carcinoma.

* * *

The regular meeting of the Maui County Medical Society was held at the Maui Palms on February 19, 1957. The members of the Society were guests of the HMSA.

Members present were: Doctors Moran, Cole, Burden, Ferkany, Tompkins, Sanders, Kanda, Izumi, Fleming, McArthur, Wong, Tong, Rockett, Patterson, Underwood, Tofukuji.

Guests present were: Doctors Boyden, Nishigaya, West, Haff, Reichert, Mr. Ralph Beck, Mr. J. Veltmann, and Mr. Albert Yuen.

It was moved by Dr. Moran to furnish polio shots to the Baldwin High School students. Dr. Moran and Dr. Tong will give the injections.

It was moved by Dr. Underwood, seconded by Dr. Ferkany, to waive the one year residence clause for the medical examination if a suitable doctor for Hana can be found.

HMSA presented their program. Much discussion followed.

Dr. Boyden, President of the Territorial Medical Society, gave a short talk to the Society which covered the following: 1. To send in the list of new officers for the year. (Some of the other Medical Societies had moved their election of officers up to December and January). 2. Whether our minutes of the Medical Society should be published in the HAWAII MEDICAL JOURNAL or not. A motion was made by Dr. Sanders, seconded by Dr. McArthur that the minutes do not go into the JOURNAL and the minutes be on an inter-island exchange. 4. HMSA renegotiation in June for Medicare. 5. Appointment of a committee at the Centennial meeting to establish citation awards for future awards for laymen and doctors. Dr. Kanda was appointed to the committee by the President. 6. Mr. Kennedy, the Executive Secretary of the Honolulu Medical Society, to represent the doctors on the HMSA Board of Directors. (Dr. Nishigaya explained that in Mr. Kennedy we would have someone there on the HMSA Board at all times who will better understand and keep a closer watch of what is going on in the HMSA.) Dr. McArthur moved, seconded by Dr. Izumi, that if the Honolulu Medical Society secure a lay representative on the Board of Directors of HMSA that he also be our representative. Motion passed unanimously. 7. We outside island doctors feel that we are dictated to by the Honolulu Medical Society because of their majority, and that in choosing our delegate to the HMSA and to the House of Delegates of the Hawaii Medical Society we should be sure that they attend the meetings. 8. The Territorial Medical Association presidency is difficult for outside island doctors especially in the matter of traveling and its expenses. Dr. McArthur mentioned that travel expenses of the President were paid by the Territorial Medical Association. 9. Reference Committee to review important points that the particular committee want to report before being presented to the House of Delegates meeting. 10. Medicare program to work on a County level. The President to appoint a committee. The following were appointed: Dr. Ferkany, Chairman; Doctors Burden, McArthur and Moran. 11. The rooms for the Territorial Convention at Kauai have been assured at the Kauai Inn and Coco Palms and the reservation should be in by March 1 or else write to Dr. Sam Wallis.

MAMORU TOFUKUJI, M.D.
Secretary-Treasurer

Hawaii

The regular monthly meeting of the Hawaii County Medical Society was held on Wednesday, February 20, 1957, at the Hilo Hotel with the Hawaii Medical Service Association acting as hosts. Doctors in attendance were: Tomoguchi, Jenkin, Brown, Okada, Matayoshi, Taniguchi, Asami, Hallick, Leslie, Luce, Hata, Oda, Crawford, Okumoto, Miyamoto, Bergin, Ota, Paynter, Woo, M. H. Chang, Loo, Willett, Kasamoto, Haraguchi, Orenstein, Yuen, Oto, Hayashi, and Mitchel. Drs. Chong and Kumagai, interns at Hilo Memorial Hospital were guests. HMSA personnel attending were: Ralph O. Beck, president of HMSA; Dr. Toru Nishigaya, Director of HMSA and president of the Honolulu County Medical Society; Dr. Rodney West, Director of HMSA and president-elect of the Honolulu County Medical Society; Joe Veltmann, executive vice-president

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A new committee to review all phases of medicine in which the Federal Government is or may become involved has been appointed by Dr. Boyden. The chairman of this committee, which is known as the Federal Medical Services Committee, is Dr. O. D. Pinkerton. Other members are Drs. C. C. McCorriston, Grover Batten, Ivar Larsen, John Felix, William Goodhue, J. Alfred Burden, and R. P. Wipperman.

Minutes of Council Meeting

Thursday, February 21, 1957—6:00 p.m. Oahu Country Club

PRESENT: Dr. Boyden, presiding; Drs. Yee, S. Nishijima, H. Q. Pang, Bennett, Hartwell, Wade, Patterson, Oto, and Fronk.

MINUTES: The Council minutes of August 14, 1956, were approved as circulated.

FINANCES: *Auditors:* Dr. Boyden advised that the auditors who had been handling the HMA account in the past had dissolved their partnership and it was, therefore, necessary to name a new auditor.

ACTION: Dr. Pang moved that we approach Mr. Hough to see if he will continue to audit the books.
The motion was seconded by Dr. Fronk and passed unanimously.

Councilors' Expenses: The probability of including the expenses of the councilors coming from the neighbor islands in the budget was discussed.

ACTION: Dr. Yee moved that the transportation, limited to air fare, and expenses, in the amount of $10.00 per diem, be paid by the Hawaii Medical Association except that these expenses would not be covered at any annual meeting.
The motion was seconded by Dr. Hartwell and passed unanimously.

BYLAWS: A discussion followed on several of the bylaws which seemed to be conflicting and it was decided to circulate the proposed changes to all counties in order that they could be acted on at the annual meeting.

COMMITTEES: *Legislative Committee:* The operations of the Legislative Committee were discussed and it was pointed out that most of the work of this committee is done when the legislature is in session. Also that the caucusing was done the year before the legislature met and it was not expedient to have one group work on the caucusing and the next group work on the actual session.

ACTION: Dr. Hartwell moved that the Legislative Committee be appointed, starting in 1957, for a period of two years.
The motion was seconded by Dr. Wade and passed unanimously.

Joint Committees: A discussion followed relative to the functions of joint committees and how they could function more smoothly.

ACTION: Dr. Wade moved that the consensus was that in order to transmit essential information between component counties of the Medical Association that we request, through the Honolulu County Board of Governors, that their executive secretary invite the executive secretary of the Medical Association as an observer at committee meetings in order that the Association's secretary may report to the component societies.
The motion was amended by Dr. Bennett to include all meetings of the Honolulu County Medical Society in order to promote mutual understanding and cooperation among the various county societies.
The motion was further amended by Dr. Wade to read that the Council should also invite the executive secretary of the Honolulu County Medical Society to all its meetings.
The motion, as amended, was seconded by Dr. Yee and passed unanimously.

PAYMENT OF DUES: Dr. Nishijima read the letter to Dr. Boyden which reported the findings of the ad hoc committee that was appointed to determine if it would be expedient to change the method of paying dues. The recommendation was to eliminate the first sentence of Section 4, Chapter IX, of the bylaws, and add the second sentence of Section 4 to Section 1 after it is changed to read "Annual dues shall be $25.00 per regular member per year to be collected from each component society and to be remitted by each component society as collected and prorated on a quarterly basis."

ACTION: Dr. Bennett moved that the change as outlined in the letter be approved subject to the acceptance by the House of Delegates.
The motion was seconded by Dr. Hartwell and passed unanimously.

GOVERNMENT CONTRACTS: *Veterans' Home Town Care Contract:* Dr. Boyden was given authority to go ahead and negotiate this contract on the basis that we should use the Medicare schedule for the fees that are outlined in that schedule.

Medicare: The fee schedule was discussed and it was decided that this matter should be referred to Honolulu County's Fee Schedule Committee.

The councilors felt that the matter of naming the fiscal agent for the new contract should be decided at the annual meeting. It was decided that a letter should be directed to the Office of the Dependents' Medical Care Program requesting an extension of time to permit our House of Delegates to name a fiscal agent for the new contract.

The meeting adjourned at 10:15 P.M.

S. NISHIJIMA, M.D.
Secretary

CLARENCE CHINN, M.D.

1898-1957

Dr. Clarence Chinn known then as Chin Cheong grew up in a neighborhood which later became the tenement district. The kids of his age group were arch rivals in school as well as in the playground. This friendly rivalry had a definite bearing in the shaping of his future. With a determination that he should not be denied the privilege of entering college, Clarence knew he had great odds to overcome.

During his early teens he realized a college course required additional expenses. Lucrative jobs for small fry were too few, cannery work was only seasonal and with a very minimum in pay. This however did not deter him from venturing onto an untried field of delivering morning and afternoon papers on shipboard. Ups and downs depended on the number of freighters in port. Radio communication was then non-existent. News from afar must be garnered from the papers. Clarence monopolized the water front, time was so pressed he had to enlist the services of his brother (Dr. Walter, now deceased). Just about then Europe was in turmoil—World War I was at full blast. After plying this successful undertaking for 2 additional years, Clarence by necessity had to relinquish the monopoly due to his graduation from high school.

In the Fall of 1917, Clarence matriculated at Creighton University in pursuit of the premedical curriculum. R.O.T.C. was wished upon him because our country was drawn into the war. Extra activities did not stop there; for he found time to supplement his schooling by working for his board.

In 1918 he transferred to the University of Chicago. In those years at Chicago besides studying, Clarence was quite observant in his outside work. He was very much exposed to the kitchen during his spare hours and did learn a few fine points in the art of Chinese cooking. His culinary skill later became his hobby. These facts can be attested to by his many friends who were able to share his hospitality. He received his M.D. from Rush in 1924.

Several years prior to his passing, his health began failing, but through determination he kept offices part time. It has been only the last two years he had to retire completely.

Clarence was a pioneer in a sense for he was the first full-time resident doctor in Windward Oahu. The district included Kaneohe, Kokokahi and Kailua which were being developed and settled.

In his passing the medical fraternity lost an ethical confrere, the community a good citizen and his family a good all around man. May his soul rest in peace.

ROBERT LEE, M.D.

Notes and News

DOCTORS

Addressed . . .

. . . surgeons

Lt. Col. Edwin Pulaski, M.C., of Tripler Army Hospital, addressed a sectional meeting of the American College of Surgeons in Seattle.

. . . Y.W.C.A. class

Drs. Harry L. Arnold, Jr., Ira D. Hirschy, and **Edwin K. Chung-Hoon** held a panel discussion on Hansen's Disease in March for the benefit of the public.

. . . the staff of Tripler Army Hospital

A symposium on surgery in acute trauma was held at Tripler U. S. Army Hospital from April 1-5, 1957. The participants and the subjects discussed in this symposium were the following:

Hormonal and Metabolic Response to Injury, **Captain Peter W. Hoagland, MC,**

Wound Contamination, Wound Infection and the Antibiotics, **Lt. Col. Edwin J. Pulaski, Jr., MC,**

Wound Shock and Debridement, **Captain Kermit Q. Vandenbos, USAF (MC),**

Fluid and Electrolyte Requirements in Injury, **Captain John L. Jackson, USAF (MC),**

Principles of Wound Healing, **Captain Robert J. Boese, USAF (MC),**

Fat Embolism, **Captain Thomas P. Talley, USAF (MC),**

Sun Stroke and Heat Exhaustion, **Captain Herbert G. Tearse, MC,**

Blast Injury in Air and Water, **Major Warren H. Brune, MC,**

Mechanisms and Management of Cold Injury, **Captain Elbert B. Fountain, MC,**

Early Care of Burns, **Captain John L. Jackson, USAF (MC),**

Tracheotomy, **Captain Kenneth B. Bonilla, MC,**

Management of Injuries of the Neck, **Captain Kermit Q. Vandenbos, USAF (MC),**

Injury of the Heart and Great Vessels, **Captain Herbert G. Tearse, MC,**

Bronchial and Pulmonary Trauma, **Major Warren H. Brune, MC,**

Injuries of the Mediastinum and Esophagus, **Captain Frank E. Ceccarelli, MC,**

Traumatic Pneumothorax, **Captain Paul A. Thomas, MC,**

Fractures of the Thoracic Cage, **Captain Robert J. Boese, USAF (MC),**

Vertebral Column Injuries, **Captain Robert R. Gatti, MC,**

Trauma to the Shoulder, Arm, Elbow and Forearm, **Commander Newman A. Hoopingarner, USN (MC),**

Trauma to Thigh, Knee and Leg, **Captain John S. Smith, MC,**

Trauma to Wrist, Hand, Ankle and Foot, **Captain Donald S. Kellam, MC,**

Tendon Trauma, **Captain Frank E. Ceccarelli, MC,**
Trauma to Pelvis and Hip, **Lt. Colonel Charles R. W. Reed, MC,**
Diagnosis and Management of Head Injuries, **Lt. Colonel Gordon T. Wannamaker, MC,**
Injuries to the Spinal Cord, **Captain Thomas P. Talley, USAF (MC),**
Peripheral Nerve Injury, **Captain Peter W. Hoagland, MC,**
Injuries to Solid Abdominal Viscera, **Captain Elbert B. Fountain, MC,**
Injuries to Hollow Abdominal Viscera, **Captain Paul A. Thomas, MC,**
Priority of Treatment in Multiple Injuries and Summation of Surgery for Acute Trauma, **Colonel Warner F. Bowers, MC.**

Winners . . .
. . . of golf tournaments

are **Drs. R. C. Durant** and **Thomas Y. K. Chang.**

Movie maker

"Ruptured Lumbar Discs—Treatment by Vertebral Body Fusion," is the title of a 20 minute color, sound film by **Dr. Ralph B. Cloward.** This film was released by E. R. Squibb & Sons. It has been so popular that out of 52 films in the Billy Burke Film Library, it is the first to have been placed in all of the branches of the E. R. Squibb Company in the United States.

New appointments to . .
. . . Division of Mental Health

Dr. George H. Stevenson, former president of the American Psychiatric Association has been appointed Chief of the Bureau of Community Service, Territorial Division of Mental Health. Dr. Stevenson, who retired after serving as professor of psychiatry at the University of Western Ontario and as superintendent of the Ontario Mental Hospital, has been doing research on drug addiction in British Columbia. He served for eight years as director of the American Board of Psychiatry and Neurology and set up various mental health programs in Canada.

. . . Shriners' Hospital

Dr. Ivar J. Larsen has been appointed chief surgeon of the Honolulu Unit, Shriners' Hospital for Crippled Children.

Distinguished visiting . . .
. . . consultants

Under the auspices of the Bureau of Medicine, U. S. Navy, a group of distinguished medical consultants of the Navy addressed the attending and house staff of Tripler Army Hospital on April 15, on the following subjects:

Primary Carcinoma of the Lung, **W. E. Adams, M.D.,**
The Newer Developments in the Care of the Orthopedic Patient, **Edward L. Compere, M.D.,**
Pain Syndromes and Their Treatment, **Rear Adm. W. McK. Craig, (MC) USNR (Ret.),**
The Physiologic Versus the Anatomic Approach to Surgical Problems, **Cdr. George Crile, Jr., (MC) USNR,**
The Craft of Medical Writing, **James Eckman, Ph.D.,**
Surgical Treatment of Soft Tissue Wounds, **Capt. Paul W. Greeley, (MC) USNR,**
Balanced Anesthesia, **John S. Lundy, M.D.,**
Therapy of Hypertension, **Rear Adm. Alphonse McMahon, (MC) USNR,**
Coronary Artery Disease, **Gilbert H. Marquardt, M.D.,**
The X-Ray Evaluation of Conditions of the Low Back, **S. A. Morton, M.D.,**
Technique and Value of Proctosigmoidoscopy, **Capt. J. Peerman Nesselrod, (MC) USNR,**
Billroth I and Billroth II Gastric Resection and Vagotomy with Gastroenterostomy, **Rear Adm. Waltman Walters, (MC) USNR.**

. . . AMA president

Dr. Dwight H. Murray, Napa, California, addressed the Honolulu Academy of General Practice on March 29.

. . . physiologist

Dr. Hans Selye of Montreal also addressed the Honolulu Academy of General Practice on April 9 on the subject of Stress.

. . . obstetrician

Dr. Louis C. Scheffey of Philadelphia, Pennsylvania, spoke before the Honolulu Obstetrics and Gynecology Society.

. . . pediatrician

Dr. Edward B. Shaw of University of California addressed the Honolulu Academy of General Practice on April 9, on The Management of Purulent Meningitis in Childhood.

New clinic members . . .
. . . Straub

Dr. Niall M. Scully and **Dr. Ralph M. Beddow** announce their association with the departments of surgery and medicine respectively of the Straub Clinic.

. . . Fronk

Dr. Newton Shuffield joined the Kaneohe branch of the Fronk Clinic. Dr. Shuffield is a graduate of the University of Arkansas. He interned at Lloyd Noland Hospital, Fairfield, Alabama. Following his internship he spent two and a half years in a general practice residency at the University of Colorado Medical Center. Prior to coming to Hawaii he practiced for two years in southern Colorado. Dr. Shuffield is married and has one child.

Travelers to . . .
. . . the Caribbean

Dr. Nils P. Larsen attended the American College of Surgeons' meeting in Boston. Following this meeting, he visited Haiti, Puerto Rico, and the Virgin Islands.

. . . the Mainland

Dr. and Mrs. Clarence Trexler left in April for a mainland vacation.

(Continued on page 550)

. . . Tokyo

Drs. Richard Y. Sakimoto, Satoru Nishijima, and **Richard Kainuma** attended the first Asiatic Congress of Obstetrics and Gynecology in Tokyo.

. . . London

Dr. and Mrs. Alfred Hartwell and **Dr. and Mrs. Charles Judd, Jr.,** attended the Harvey Tercentary Congress in London.

. . . Belgium

Dr. and Mrs. Ralph B. Cloward are attending the meetings of the International Neurological Congress in Brussels, Belgium.

NEWS

Doctors Wanted

The following openings for doctors have been listed with the Hawaii Medical Association office. For further information call 57907.

Pearl Harbor Naval Shipyard
Pearl Harbor Naval Supply Center
American Samoa
Parker Ranch

Diabetes Movie

The film "Urine Sugar Analysis for Diabetics," developed in cooperation with the medical profession, is available at no charge to the medical and allied professions through Ames Company, Inc.

The film was made as a visual aid to be used in the education of diabetic patients and shows the relationship between carbohydrates and insulin. It also explains in lay language the meaning of various diabetic conditions. It has been produced on 16 mm. film in color and sound track with a running time of approximately 10 minutes. Appropriate "hand-out" literature accompanies the film.

Showings at diabetic clinics, diabetic lay societies and other diabetic groups must be requested by the medical or allied professions to Ames Company, Inc., Elkhart, Indiana or an Ames representative.

Mother and Baby Care Classes

All doctors interested in a consolidated list of Mother and Baby Care classes scheduled on Oahu may contact Nursing Services, Hawaii Red Cross, 453 South Beretania, phone 5-2571.

No More Books for Korea

The American-Korean Foundation and the United States Army Medical Service have announced the discontinuation of their joint project of shipping medical books contributed by individual physicians, medical schools, hospitals and state and local medical societies to Korea.

In making the announcement, Howard A. Rusk, M.D., President, American-Korean Foundation said, "the response of physicians and medical groups throughout the country for our appeal for books for Korean medical schools has been so generous that further contributions are not needed." As a result of this program, Dr. Rusk stated, over 77 tons, valued at $76,000, of medical texts, references and periodicals have been shipped to Korea for distribution to Korean medical schools.

Free Cardiac Surgery Program

National Jewish Hospital at Denver is expanding its cardio-vascular program. It will consider applications for admission in behalf of patients suffering from cardio-vascular defects amenable to surgical intervention, including mitral and aortic stenosis, congenital cardiac anomalies, etc. Definitive diagnosis is not necessary prior to admission, inasmuch as the hospital has a completely equipped cardio-pulmonary physiology laboratory for this purpose. Patients are accepted without respect to race, religion, or national origin, and without charge. Only those unable to pay for private care are eligible. Periodic reports are made routinely to the referring physician and the patient is directed to report to him after discharge. Inquiries should be sent to Medical Director, National Jewish Hospital, Denver 6, Colorado.

Scholarship Program

The Hawaii Chapter of the National Society for Crippled Children and Adults is sponsoring a scholarship program for which physicians, therapists, educators and other professional workers may qualify. For further information call Mrs. McComas at 63764.

MEETINGS

For additional information call Honolulu 5-7907.

Hawaii

Pan-Pacific Surgical Association
Triennial Meeting—Honolulu—November 14 to 22, 1957

Mainland

California

Children's Hospital of the East Bay, Seminar—Oakland—June 7 to 8

St. John's Hospital Annual Postgraduate Assembly—Santa Monica—September 12 to 14

San Francisco Heart Association 28th Annual Postgraduate Symposium on Heart Disease—San Francisco—October 2 to 4

First Western Industrial Health Conference—Los Angeles—October 4 to 6

San Diego County Heart Association Fall Symposium on Heart Disease—San Diego—October 8

Los Angeles County Heart Association 27th Annual Symposium on Heart Disease—Los Angeles—October 9 to 10

California Society of Internal Medicine Annual Meeting—Palm Springs—October 25 to 27

Colorado

Rocky Mountain Cancer Conference—Denver—July 10 to 11

Georgia

9th Postgraduate Assembly in Endocrinology and Metabolism—Augusta—October 21 to 25

(*Continued on page 576*)

Woman's Auxiliary

Reports

The "Evening at Home" sponsored by the Woman's Auxiliary to the Honolulu County Medical Society on March 21, 1957, has been quite successful. Over 3,000 letters with tickets were sent out and the Auxiliary will be able to send a check to the American Medical Education Foundation for over $1,000, with returns still coming in.

This project was attempted in honor of Doctor's Day and the contribution will be made by the Auxiliary to the A.M.E.F. in honor of the Honolulu County Medical Society.

* * *

The National Theme for the program of 1956-1957 is "Health is Our Greatest Heritage." There are five major fields of interest in this year's National Program. Because of the broad scope of this program, topics have been arranged as follows —"Understanding Our Health Heritage," "Building Our Future Health Heritage," "Preserving Our Health Heritage," "Defending Our Heritage," and "Interpreting Our Health Heritage to The Public."

The first topic, "Understanding Our Health Heritage," has Community Health Facilities in its program which in turn has Medical Societies, Tax-Supported Health Agencies, Voluntary Health Agencies and Hospitals, and Treatment Centers as facilities included.

The second topic, "Building Our Future Health Heritage," has under its program American Medical Education Foundation, Recruitment, Maternal and Child Health, and School Health.

The third topic, "Preserving Our Health Heritage," has under its program Safety, Rehabilitation, Mental Health, Care of Aging and Chronically Ill, Nutrition and Overweight.

The fourth topic, "Defending Our Heritage," has under its program Civil Defense, Legislation, Hoover Commission Report, and American Heritage Foundation.

The fifth topic, "Interpreting Our Health Heritage to The Public," has under its program Public Relations, Science Fairs, Assisting Other Organizations in Health Programs, and *Today's Health* magazine.

There are many other aspects of the Auxiliary Program such as Socials, Study Groups, Benefits, Health Exhibits, Health Films, and programs in general which are too numerous to mention.

We here in Hawaii are in an indirect way carrying on our Auxiliary programs similar to the National program. Our island auxiliaries are fortunate in having members who participate and assume leadership in these various activities and programs.

As the National President says, "Good planning must have good cooperation."

MRS. MAMORU TOFUKUJI, *Chairman,*
Program Committee, W.A.H.M.A.

County News

Maui

Maui Pineapple Company and its president, Mr. J. Walter Cameron, entertained the Maui County Medical Association and its Woman's Auxiliary for dinner at the newly remodeled and redecorated Haliimaile Dispensary on April 16. Hosts for the cocktail hour were Dr. J. Alfred Burden, Maui Pine physician, and his associate, Dr. Frederick Reichert. This was an opportunity for several members of the professional group to view this treatment center which otherwise they have no occasion to visit.

The doctors held a business meeting at the same place after dinner. Their wives adjourned to the Makawao residence of Dr. and Mrs. Burden for the annual meeting and election of officers. Maui Auxiliary officers for 1957-1958 will be:

Mrs. Harold Kushi, president
Mrs. Joseph Ferkany, first vice-president
Mrs. Ah Yet Wong, second vice-president
Mrs. Frank St. Sure, Jr., secretary-treasurer
Mrs. Joseph Sowers, corresponding secretary

Honolulu

The spring meeting of the Honolulu Auxiliary was a demonstration of cooking in the electronic oven. Miss Helen Brown, home economist, exhibited this marvelous new equipment in the Hawaiian Electric Company's demonstration kitchen on March 5. The audience all enjoyed tidbits of the beef roast and samples of the cake cooked by this miraculously rapid method.

Preceding the cooking demonstration, Mrs. Louis Buzaid, president, conducted a brief busi-

(*Continued on page 575*)

INTER-ISLAND NURSES' BULLETIN

Official Publication of the Nurses' Association, Territory of Hawaii

ROSIE CHANG, *Editor*

DORIS GREGORY, *Associate Editor*
NORA SHIROMA, *Associate Editor*

ANNE CAMARA, *Associate Editor*
MILDRED KIM, *Associate Editor*

OLIVE C. PRIDGEN, *Executive Secretary*



RADIO BROADCAST

Via the radio waves, local KMVI radio station gives the MDNA President, Mrs. Michie Kamitake, the courtesy to be heard on Mrs. Erma Crane's "To The Ladies" program.

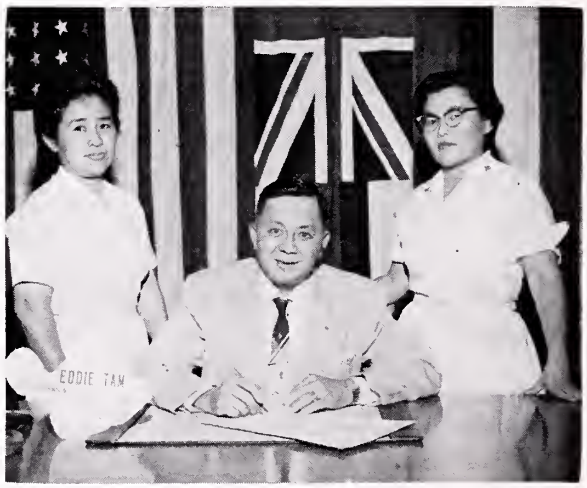
Featuring

Maui Nurses



IN THE LIBRARY

Mrs. Gloria Foster, MDNA Professional Advancement Chairman, presenting and discussing with Miss Lucille Berg, Head Librarian, Maui County Free Library, a book purchased by the Association to be added on the Nursing Bookshelf Collection.



HOSPITAL WEEK PROCLAMATION

Mrs. Yukiko Higa, Acting Director of Nurses at Central Maui Memorial Hospital, and Mrs. Miriam Mukai, MDNA Publicity Chairman, witnessing the proclamation of National Hospital Week —May 12 through May 18 by the Honorable Maui County Chairman, "Friendly" Eddie Tam, at the Board of Supervisors' chamber room.

Editorials

This edition of the INTER-ISLAND NURSES' BULLETIN features the Maui District Nurses' Association. Maui, the Valley Isle, comprises 128 square miles of land and is 101 air miles from Oahu. It is the second largest inhabited Hawaiian Island. Approximately 39,000 people of all races live on Maui. According to the Board for the Licensing of Nurses' statistics on nurse population (1956 fiscal report), 86 nurses are currently licensed on Maui. According to NATH office figures for the same year, 86 are members of their district association. Congratulations! *Maui No Ka Oi!*

A few months ago, Maui District Nurses' Association invited NATH Legislative Committee Chairman, Chairman of Board for Licensing of Nurses, and Director of Nursing of Territorial Hospital, to present NATH's Legislative Program to their island legislators. This was a success in more ways than one. Maui nurses are to be commended.

Within this issue, you will read of their community activities, association progress and projects and plans for the future.



IN FRONT OF THE NASKA HEADQUARTERS

The Maui District Nurses' Association acquired the above quonset hut from the Hawaii Housing Authority in Kahului, Maui. Monies realized from various projects have been annually forwarded towards the general repairing, maintenance, and installation of modern, convenient kitchen and bathroom privileges as well as attractive interior decorations and furnishings.

Left to right—front row: Miss Helen Goshi, recording secretary; Mrs. Marjorie Okinaka, vice president and NATH board member; Mrs. Hilda Yatsushiro and Mrs. Margaret Alexander, board members-elect. Second row: Miss Ruth Ikeda, board member-elect; Mrs. Miriam Mukai, publicity chair and board member-elect. Top row: Mrs. Yukiko Higa, Civil Defense chair and board member-elect.

NURSING AT KULA

Stories of early beginnings in the old home town do not stir the imagination nor quicken the pulse like "tales of far away places with strange sounding names." So it is with nursing at home. Young aspirants to the profession are thrilled by the heroic deeds of nurses on the battlefield of North Africa. They devour the food for thought found in the saga of nurses on horseback in Kentucky, on snow shoes in Sitka, or on river boats in Hong Kong. What, they muse, could be stimulating about the challenge to nurses on Maui, especially at Kula! Nothing ever happens at Kula! Everybody knows that! It has always been that way! An established, serene, calm appearance belies the story of struggle against prejudice, ignorance and fear. The first nurses at Kula were pioneering in the fullest sense in a truly exotic land. Many exciting chapters have been written in the struggle against tuberculosis which are found in the routine files at Kula Sanatorium. The nurses should be given a measure of credit for the victory which is being won.

The realization of a dream come true was manifested in a concrete way with the erection of two tent wards and a cook house with a dining room. It was 1910 and the magnificent sum of $500.00 had been made available by the Territory and the County to build a place to care for patients with the "Coughing Disease." The dreamers, Dr. W. F. McConkey, Mr. Harry A. Baldwin, and Mr. William Pogue, were looking toward the future when *more* than twelve patients could be accommodated at Kula Sanatorium. Public funds and private donations developed this institution into the modern plant it is today.

The first Director of Nursing was Mrs. Rebecca Akana Lane. Her fine contribution to nursing can be seen in the remarkable groundwork done in this remote area on the slopes of Haleakala. Mrs. W. E. Foster was the Nurse Administrator in 1912 and worked tirelessly for better conditions. Gloria Williams Foster, Miriam Crabbe Schmidling, and Effie Dewar can spin some magnificent yarns about early nursing situations which were only routine—caring for patients during a flu epidemic, evacuating patients because of water shortages. They recall riding on horseback to small farms which dotted the mountainside to assist in bringing a potential President of the United States into the world—well, at least, a potential Governor of the Territory! The children in the Fresh Air Camp, or Preventorium, were the source of many a nursing challenge. The cod liver oil administration technique was classic. It occurred outside in the sun after breakfast. The nurse held the bottle and an adequate supply of spoons while she reminded the little ones "No medicine, no play!" There were few non-takers.

Extensive case finding studies were made by doctors whose names are familiar: Dr. C. J. Wilen, Dr. R. T. Eklund, and Dr. Homer Izumi. 32,601 persons were skin tested between 1934 and 1940. Thoracoplasties were performed first in the 20's by Dr. F. G. Edwards. Dr. E. A. Tompkins, present superintendent, and Dr. Joseph E. Ferkany, chest surgeon, make up the surgical team today.

Myrtle Payne, Flora Smith, and Miss Shellshire experienced the growing pains of Kula. Helen Madsen Gage was on hand to see the opening of the new building in 1937. Rosina Bruhn, Mabel Gordon, and Ethel Simonson Butchart saw the development of the modern nursing techniques made possible with the new facilities and equipment. Your narrator has been the Director of Nursing for eleven years and has witnessed great revolution in medical and nursing techniques from pneumothorax and pneumoperitoneum therapy, phrenic surgery and a maximum bed rest program to present day chemotherapy and pulmonary resection resulting in earlier ambulation and shorter hospitalization periods.

It is heart warming to know that two of our nurses are Kula girls: Mrs. Hattie Kapohakimohewa Makua and Miss Yasuko Carol Kusakabe. Many of our practical nurses were delivered in this hospital where they are today employed. Kula is like a large family with all its joys and problems. The Nursing Service attempts to mix modern techniques and methods with a great deal of tender loving care to provide the skilled, concerned attention required for the comfort and well being of the patient with tuberculosis.

ELIZABETH S. MCCALL, R.N.

THE REGISTERED NURSE

A survey of the social and occupational characteristics of the registered nurse has recently been made by Community Studies, Inc., of Kansas City, Missouri, under the auspices of the American Nurses' Foundation. The following concluding note to this study contains implications for those who are recruiting, preparing, and employing nurses.

"In this report we have taken a close look at the social and occupational characteristics of a metropolitan-area nurse complement. The complement, which includes all persons who are graduate nurses, was broken down into its component parts, and it soon became obvious that nurses are not all alike, in spite of the fact that there is a tendency for both lay persons and those who should know better (including nurses themselves) to speak categorically (and stereotypically) of 'the nurse' as though she were a breed of animal unto herself. The data indicate clearly that it is not reasonable

to think in terms of 'the nurse': there are many kinds of nurses, who differ from each other both in terms of their occupational and their social characteristics. The nurse who works is not the same as the nurse who is not employed; older nurses differ from younger ones; married nurses have different characteristics and attitudes from single ones. Nurses differ in terms of the kind of training they have had, the setting they work in, and, most important, the field of nursing in which they practice. It is almost possible to conceive of private-duty, office nursing, public health, general-duty, industry, and the other fields as different occupations.

"These observations bear directly on a number of problems which concern the nursing profession at present. Differences in background, characteristics, and attitudes suggest that different recruitment techniques, methods, and appeals are required in order to attract potential nurses into different fields. It is probably true that more severe shortages exist in some fields of nursing than in others; if this is true, then recruitment and training should be designed and shaped in terms of those fields. If the fields of nursing differ as much from one another as the data suggest, why should all student nurses receive the same training? Might not curricula be modified to meet more specific demands and interests? There are, certainly, kinds of knowledge and techniques required of a general-duty staff nurse which are utterly useless to a school nurse or a public health nurse and *vice versa.*

"There can be little doubt but that nurses in some fields are motivated in radically different ways from those in other fields and that the kinds of satisfactions sought and derived from these various types of nursing also differ radically. This area of motivation and especially of job satisfaction is one in which further research is desperately needed. This report has literally been a description of a survey rather than a research project in the true sense of the word. The basic data included here provide the necessary descriptive and background information required for the formation of reasonable research hypotheses concerning the nurse and her work as it relates to and differs from other nurses and their work and the complement of graduate nurses in general. It is currently being employed as a base line for other research being conducted in the Kansas City area, and it is hoped that it will be of value to those working in this field in other parts of the United States, not only for research purposes, but also in coping more intelligently with problems involved in recruitment, nursing education, and nursing shortages."

The foregoing is quoted from *A Survey of the Social Occupational Characteristics of a Metropolitan Nurse Complement,* Part 3 of *A Study of the Registered Nurse in a Metropolitan Community,* Community Studies, Inc., Kansas City, Missouri, November 1956.

HALIIMAILE DISPENSARY

On the basis of half-a-day work schedule R.N.'s Mrs. Anne Fitzgerald, Katherine McPhee, Mrs. Modesta Singlehurst, and Mrs. Lillian Gill give light to the Industrial Nursing history at Haliimaile Dispensary on Maui. The hands of time wind back to the year 1932, the date of incorporation of Maui Pineapple Company. Fifteen years later, 1947, the first full-time R.N., Miss Dorothy Grey, was appointed.

In 1948 Miss Eileen McHenry, at present MDNA Board Member-elect, arrived at Haliimaile Dispensary. Later an addition to the staff was necessary with the increased work load. It was at this time Mrs. Wyoma Carey Bradley shared the nursing responsibilities with Miss McHenry.

This year of 1957 brings further progress. The Dispensary has been remodelled and modern facilities installed.

The staff now includes Dr. J. Alfred Burden, Medical Director; Dr. Frederick L. Reichert; Miss Eileen McHenry, Head Nurse; Mrs. Alma Anton, nurse; Mrs. Ann Cumming, nurse-receptionist; an x-ray and laboratory technician; and a nurse's aide.

With a new emergency surgery, centralized and enlarged treatment center, new utility area, improved x-ray facilities, enlarged laboratory, new office, and new patients' waiting room this Dispensary is one of the most modern and complete treatment centers on Maui.

PUBLIC HEALTH NURSING— MAUI COUNTY

The first public health nurse for the island of Maui was appointed in 1916. Her work was confined to tuberculosis as this was the paramount health problem at the time. In 1919 an additional nurse was added to do school nursing. In 1921 another part-time nurse was added to do tuberculosis work. From time to time, additional nurses were added and services increased. In 1932 Maui had a nursing staff of one supervisor and five field nurses and Molokai had two field nurses. Services offered were divided into four divisions; namely, maternity health supervision, morbidity (which included communicable and non-communicable diseases), and social service.

The first public health nurse for the island of Lanai was assigned in January, 1936.

At present, Maui County enjoys a staff of one supervisor, one assistant supervisor, and nine staff nurses who offer services in many health fields.

The public health nurse meets your community needs through the services she renders. As the

agent of the Health Department closest to the people, the nurse carries the knowledge of preventive medicine into the homes of families in all walks of life.

The public health nurse's work centers on the family and stretches out from the home into all parts of community life. In carrying out her activities, the nurse works closely with the physician, sanitarian, health educator, and other members of the health team. In the same way, she cooperates with civic groups and leaders, with other professional workers, as well as with the community's social agencies, church groups, and similar organizations.

Because the public health nurse works with the family in the home, she can serve them both as a nurse and teacher of health. She strives always for early medical diagnosis and treatment and assists the family in carrying out the doctor's orders. Where bedside nursing care is necessary, the nurse gives the care, demonstrates to the person attending the patient, or arranges for the family to get such care.

At health centers, the public health nurse works with the physician and explains the whys and hows of treatment to patients. When a case of syphilis or tuberculosis, for instance, is reported to the health department, the nurse interviews the patient, traces the contacts, and plans the necessary nursing service in the clinic or the home.

The nurse's activities take in many aspects of community health not commonly associated with nursing. For example, while visiting a family on an accident case, she may draw attention to the screenless windows and the danger of flies. When she assists in getting a birth registered, she is dealing in vital statistics. On a chronic disease call, the broken down well in the back yard may prompt her to arrange for a visit by the sanitarian.

Similarly, the public health nurse stimulates and takes part in community action for playgrounds, day-care centers, clubs for boys and girls, and other organizations and facilities which mean better health and safety for all.

For just as prevention and cure are two sides of the same problem, so are individual and community health. By guiding the family toward better health, by helping them prevent disease before it strikes, the public health nurses safeguard and improve the general health of the community as a whole.

The public health nurse is your friend in green and white.

MRS. LAURA D. WONG
Supervisor,
Department of Health, Maui

HISTORY OF CENTRAL MAUI MEMORIAL HOSPITAL

In the 1866 report of the Board of Health to the Legislature of the Kingdom of Hawaii, it was recommended that small hospitals of about twenty beds each be established on each island. The earliest specific communication thus far found in relation to the establishment of a hospital in Wailuku was written on July 24, 1875, by Jno M. Kapena of Lahaina, then Governor of Maui. The letter was addressed to His Excellency, W. L. Moepali, Minister of Interior, Kingdom of Hawaii. The following are excerpts taken from this letter:

". . . When I arrived at Wailuku, the government physician told me that the Board of Health had approved of the plan to build the hospital, which was considered, at the District of Wailuku, for the benefit of the people whose bodies are wasting, of the Island of Maui here. This proposition, the building of a hospital on this Island, is one of the very best acts, supporting the stake of the Kingdom, of our Revered Ruler, and it would be well to start immediately.

"Dr. Enders, President of the Board of Health, told me that you have appointed me as chairman of the committee to superintend all things pertaining to the work of the hospital which is being considered to build; . . . but, I have not duly heard from you, and from the secretary of the Board of Health as to the true decision regarding it, so that I may have the help of authority of the appointment being made to call, and to set up immediately a first meeting for its consideration.

"If the first meeting should be called, and the proceedings pertaining to the construction of the hospital is successful, then, I shall lend all my influence and encouragement so that this work may be successful, and so that the people whose bodies are wasting may come in great numbers seeking remedy of their bruises, and to retard the patienceless destruction of the King of death upon our beloved nation . . .

". . . From their appearance, it seems that, there is a great number of sick and weak people, and they are very desirous of seeking remedy and comfort of the Queen's Hospital, at Honolulu; but, because of the distance that is holding back those that are sick in the country from going to seek remedy within the helpful kindly enclosures of the Queen's Hospital. There is in the country districts where the sickness has been found to be very fearful, because when they went to Honolulu, they contracted sickness, and returned to spread it in the country districts, where there is no help and no attention of skilled doctors . . ."

After the Legislature of the Kingdom of Hawaii had appropriated funds to its Board of Health for

the construction of a hospital, Malulani, at Wailuku and the building was completed at Lower Main and Mill Streets, it stood idle because of staffing problems.

On January 22, 1884, Queen Kapiolani, through Walter Murray Gibson, her Minister of Health, appealed to the Franciscan Sisters for aid to open and operate the new hospital in Wailuku. In response to an earlier plea of Queen Kapiolani's, the Franciscan Sisters arrived in Honolulu on November 9, 1883, to take charge of the Branch Leper Hospital at Kakaako in Honolulu.

Mother Marianne, Sister Renata, and Sister Antonella took formal charge of the new Wailuku hospital on April 24, 1884. Queen Kapiolani named the new hospital "Malulani" (Protection of Heaven) and placed it under the special patronage of Her Royal Highness, the young Princess Liliuokalani. Soon after the opening of Malulani Hospital, Mother Marianne was recalled to Kakaako. Mother Marianne went to Molokai in 1888 where she became one of the great heroines of the leprosy colony at Kalaupapa Settlement.

The Franciscan Sisters discontinued the operation of Malulani Hospital in 1927, at which time the County of Maui assumed full responsibility for its operation, management, and financial support.

With the passing of time, the County of Maui planned for a new, modern hospital to care for the sick and injured. Plans were drawn up for a veterans' memorial to be known as the Central Maui Memorial Hospital.

The hospital site was one of battle grounds of the ancient Hawaiian kings. The Battle of Iao, a bloody, violent engagement between Prince Kalanikupule of Maui and Kamehameha's invading army, was within the area on which the hospital now stands. The new hospital began to serve the people of Maui on September 15, 1952.

At this present time, more than half of the total staff at Central Maui Memorial Hospital is engaged in nursing service.

President's Message

REFLECTIONS IN MID-STREAM

The halfway point of our association year has been reached with this June issue of the *Inter-Island Nurses' Bulletin*. So far the year has seen much heightened activity in all areas. If this continues, we will assure ourselves of a year well spent and marked by great progress.



LYNNE WIGEN, *President*

Two sections have worked for the advancement of our professional knowledge by planning institutes. The one-day program at the Princess Kaiulani Hotel on "Effective Communication" was executed by the EACT section of NATH. The INSA section is currently working on plans for extremely comprehensive refresher courses.

In the field of economic security, the public health nurses are working on minimum employment standards, meeting frequently in order to have them ready for presentation this year. The private duty nurses are also discussing minimum rates and employment standards. Such section activity is only possible where the genuine interest of each member is brought to fruition on matters which are of vital concern to the individual.

It seems that we have strengthened our own professional relationship by unity of action and joint purposes during the last legislative session.

Some decisions affecting the year's work were made at the March board meeting. The association has agreed to participate in the ANA Membership Roll Call next year and has set aside funds for this purpose. A new Income Protection Insurance Plan was discussed from materials presented by Brainard & Black upon the recommendation of the Economic Security Committee. The members of the board felt that this group plan was well worth considering and moved that we go on record as approving the disability plan for our membership.

The second half of 1957 will be climaxed with the convention on Hawaii, the action of the House of Delegates upon these beginnings, and the further expressed desires of our enthusiastic membership.

Let's not be satisfied with halfway programs—this is only the beginning.

LYNNE WIGEN, R.N.

Clinical and Technical

LAMINECTOMY, A STUDENT NURSING CARE STUDY

This is a nursing care study of a 48 year old Caucasian male who is a minister by vocation. He has been very active in many organizations. With all these activities, he manages to spend some time on his hobby of photography.



JANET SAWAGUCHI

Rev. J., a resident of Honolulu, has been a widower for 23 years and has a son who is married and lives on the mainland. His parents are both living and well and reside on the other side of the island.

For relaxation, Rev. J. enjoys swimming. One October day while swimming he dove from a low diving board. From that time he began having low back pain in the lumbosacral area. This pain progressively became worse, with radiation of pain down the posterior aspect of his right leg. Rev. J. did not think much about it until a week later when the pain had progressed so much that he was almost unable to move. When his doctor saw him, he immediately sent the patient to the hospital in an ambulance.

At the time of admission to the hospital, his backache was so intense that he was uncomfortable even lying down. The routine admission procedures, such as blood pressure, temperature, pulse, respiration, were done. Also, the general condition of the patient was noted. The routine laboratory tests, urinalysis and complete blood count were essentially negative.

On the day of admission the psychological, as well as the physical, care of the patient should begin. "The psychological care of the patient in many respects, is the no-man's land of surgery. Everyone has a claim on it, but no one really owns it. In other areas, responsibility is well defined. Here it is not. Surgical management is clearly the surgeon's job, the anesthesia belongs to the anesthesiologist, and the nurse has certain prescribed duties. But the psychological care is widely divided so that everyone who comes in contact with the patient has a hand in it. Not only the surgeon, the anesthesiologist and the nurse, but also the social workers, ward aids, clergymen, relatives, and even other patients all have a variable but definite impact upon the patient's mental life."[1]

It is important that the nurse establish a good rapport with the patient so he will feel confident and it will help him to express fully his thoughts and feelings which may be bothering him. Rev. J. admitted that he was "scared stiff" at the thought of coming to the hospital and everything associated with it. The nurse's first responsibility was to reassure him and try to make him as comfortable as possible.

The nurse must be alert to the patient's signs and symptoms. The type of pain, muscular weakness of the arms and legs, numbness, stiffness, tingling of hands and feet, bowel and bladder dysfunction or anesthesia of skin should be reported to the physician immediately.

The medical history revealed that Rev. J. had a tonsillectomy, a cholecystectomy, and two years ago two intervertebral discs were removed. At that time a spinal fusion was not performed.

On the day of hospitalization Rev. J. was put on bedrest and on a general diet. Demerol 75 mgm was given for pain, and at bedtime Seconal gr ½ was administered to help induce sleep.

The following day, the patient's physician consulted the surgeon concerning the possibility of a laminectomy and a spinal fusion. In examining the patient, the surgeon found that the patient had severe sensory loss, in fact almost a saddle block, which indicated that there was pressure on certain nerve roots. Because of this finding, an emergency laminectomy was scheduled for the following day.

On the evening prior to surgery Rev. J. was prepared in this manner:

1. Blood was drawn for type and cross match for two units of whole blood.
2. Bleeding and clotting time were taken.
3. S S enema was given.
4. Seconal gr ½ was given at bedtime.
5. The skin was prepared by shaving the lumbosacral area and also the right leg from the ankles to just above the knee. The skin was then thoroughly cleansed with phisoderm.
6. Nothing was given by mouth after midnight.

At 9 A.M. the following morning a preoperative

[1] Bird, Brian: Psychological Aspects of Preoperative and Postoperative Care, Am. J. of Nursing 55:685-687 (June) 1955.

medication of Sodium Luminal was given intramuscularly into the right deltoid. This helped to lessen the apprehension of the patient and to aid in the induction of anesthesia. Demerol 100 mgm and atropine gr 1/150 were administered intramuscularly at 10 A.M.

An hour later a general anesthetic was administered and a lumbosacral laminectomy was performed.

The surgical procedure was actually three operations in one: removal of the bone grafts, laminectomy and removal of the intervertebral disc, and lastly, the spinal fusion. The bone for the fusion was taken from the tibia of Rev. J.'s right leg.

A bone plug was inserted between the lumbosacral joint and chips of bone were scattered posterior to the spinal column. After the wound was closed, a dry sterile dressing was placed and taped over the incision.

Many a successful operation has been undone by inadequate postoperative care. This care must begin from the moment the patient leaves the operating table. Rev. J. was placed directly on his bed, which consisted of two mattresses and a board placed on the springs. The top mattress was sponge rubber and the other, cotton. Because it is essential that the alignment of the post-laminectomy patient be noted, his transfer from the operating table to his bed was supervised by the doctor, anesthetist and other authorized persons.

Upon the patient's return to his room, the nurse found that his pulse and respiration were regular and of good quality. His skin was warm and dry to touch. Until the patient regained full consciousness, the nurse remained in constant attendance.

Careful postoperative observation of the patient is essential. Blood pressure must be checked frequently. The trauma to the body is by no means slight and there usually is a significant loss of body fluids which may result in shock. If this had occurred, parenteral fluids would have been given. Since hemorrhage also may complicate the patient's recovery, the dressings both of the patient's back and right leg were checked for bleeding and drainage.

Edema, the presence of a hematoma in the operative area, or trauma to the nerve during operation may cause symptoms of impaired motor or sensory functions in the lower extremities. An hourly check of the patient's ability to dorsiflex his feet was made, and also the movement of his toes was checked.

Rev. J.'s right leg was elevated on sandbags and supported. To avoid as much discomfort as possible, the initial dose of Dicrysticin was given into his right gluteus while he was still under the effects of the anesthesia. Dicrysticin, a combination of procaine penicillin, and streptomycin, was given as a prophylactic measure.

When the patient regained consciousness he was instructed to remain flat in bed for 72 hours and any movements were to be supervised or done by the nurse. Fluids were given as tolerated after the post nausea period. The nurse was alert to record the fluid intake.

Demerol, 100 mgm, was given for pain every three to four hours in an attempt to keep the patient as comfortable as possible.

Later that day the doctor gave the nurse permission to place small pillows under the patient's head and under his knees. With these supports the patient was more comfortable. Ice bags were placed on the donor leg which was causing Rev. J. much discomfort. This helped prevent bleeding.

Liquids were provided for the patient the first evening following surgery. He was then placed on a house diet.

During the first 72 hours when the patient was required to stay flat in bed, the nurse used a draw sheet to turn him on his side to give back care. It was also necessary to have another nurse hold the patient in place while he was on his side.

When the spinal cord is injured the skin is deprived of its sensation and is extremely sensitive to pressure. Meticulous precautions were taken in the care of Rev. J.'s skin to avoid decubitus ulcers especially on bony prominences. His position was changed every two hours for the first few postoperative days until he was able to turn himself. Medicated alcohol was used to rub his back, and baby powder was used to keep the skin as dry as possible. The lower sheet was kept smooth and taut.

Careful attention is given to the care of the bladder because after a spinal operation there may be difficulty in voiding. Because the patient was unable to void within eight hours following surgery, a Foley catheter was inserted by an orderly. About four days later the catheter was removed and immediately after he voided the first specimen, he was catheterized for residual urine. The catheter was left in place because the residual was 350 cc. Rev. J. was rather disturbed about this, so it was explained to him that the doctor wanted to make sure that his bladder was not distended. Gantrisin was begun to counteract any possible urinary infection.

The saddle-like numbness, which Rev. J. had prior to surgery, was slowly diminishing. Since the patient was having abdominal distention, a rectal tube was inserted so that flatus might be expelled. To avoid straining his back, bowel movement was controlled until the fifth postoperative day. On the night of the fourth postoperative day one ounce Milk of Magnesia was given to

stimulate a bowel movement. Because it produced no result, a soap suds enema was given. The patient was carefully placed on the bedpan, and was given firm support.

Throughout his hospitalization Rev. J. was given frequent cathartics and enemas to regulate and aid him to have bowel movements. Unfortunately, the patient had a fecal impaction and experienced discomfort which might have been avoided if an enema had been given a day sooner.

During his long hospitalization Rev. J. made good use of his time. After it was approved by his doctor, he began occupational therapy work. Since Christmas was approaching, he produced some attractive gift articles. He spent time in framing some of his many slides. He also carried on an active correspondence.

One of the most important phases of care of a laminectomy patient is detailed teaching throughout his hospitalization. After eight days he was allowed to turn from side to side, and was instructed to roll as a unit. A descriptive term that could have been used in explaining this was, "roll like a log." At first because of muscle weakness caused by disease, and because of lack of confidence in himself, Rev. J. needed considerable assistance in changing position. However, in three to four days he was able to turn from side to side in a unit with no difficulty.

Four days prior to his discharge a brace company was called to fit Rev. J. After the brace was fitted the nurse instructed and supervised the patient in applying it before he was permitted up. He was also instructed that he must always put on the brace before getting out of bed, and to keep it on until he was again in bed.

To avoid as much straining of his back as possible, the patient was taught to get out of bed properly. Instead of using his back muscles, he was taught to push up with his arms and swing his legs to the side of the bed to get into a sitting position. The nurse also stressed the importance of good posture in activities and in sitting.

For the first few months at home the patient was told to avoid jarring his donor leg. The patient was taught how to use an elastic bandage if the donor leg swelled after walking.

Rev. J. was walking with crutches for three days before he was discharged from the hospital. He spent a convalescent period of three weeks with his parents in their home. From his doctor, it was learned recently that Rev. J. had returned to his work and is progressing very well.

To give intelligent care to a laminectomy patient, the nurse must realize that there is no standard pattern to follow. Each patient's treatment and nursing care depends on his medical and individual problems as a person. Some patients adjust easily to the hospital routine, having little postoperative discomfort, no complications, and present few nursing problems. Others present complex problems which will call for marked ingenuity and insight on the part of the nurse.

Rev. J. was a cheerful, cooperative patient and contributed much to the learning experience of the writer.

JANET SAWAGUCHI,
University of Hawaii School of Nursing

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General Interest

MABEL LEILANI SMYTH

Forty-three years do not make a long life, but the forty-three years of Miss Mabel Smyth's life mark an outstanding achievement and unusual completeness.

She was born in Honolulu on September 1, 1892, and spent her early childhood on her part-Hawaiian mother's land at Kona. Her father was Irish-English, Captain Halford Hamill Smyth of the Inter-Island fleet. She was the guide and companion of her older sister who from birth had only partial sight. At eighteen, she finished her high school work in Honolulu, where the family had moved just before Captain Smyth's death.

At twenty-two she was graduated from nursing school in Massachusetts. She returned to Honolulu and at twenty-three she went to work as district nurse at Palama Settlement, where she later served as head nurse. At thirty, she took her older sister to Massachusetts. While there she graduated from a course in Public Health Nursing at Simmons College. At thirty-five she became director of the Public Health Nursing Department of the Territorial Board of Health. Before she was forty she

had several times represented Hawaii in Washington and at other mainland public health conferences.

At forty-three she put in perfect order every detail in her home and office before entering the hospital for an operation. She died March 24, 1936.

These facts of a completed life tell little of that life. Yet they give such vivid glimpses into it that, knowing them, even a stranger would search with eager interest into the pathways and streams which led into and enriched those forty-three years, so short and so full. Those who knew and loved Mabel Smyth are many. For them the almost overwhelming tide of grief and bewilderment at her sudden passing must finally merge into the calmer contemplation of that life as a definite, exquisite work of art in which "every stroke counted."

Longest and perhaps most profound in the life of Mabel Smyth have been the influence of her fine Hawaiian mother, her Irish father, her two sisters and three brothers, and her busy childhood on the Kona hillside. Her personal thought was bound up in the home which her hand continued as a shelter for aging mother and handicapped sister. It was her very life. In Kona her mother had helped out the family budget by braiding fine lauhala hats for sale. It was her mother and her mother's people who trained the Smyth children to pick and clean coffee on their own farm, to ride horseback into the uplands to plant their own dry land taro, and pound their own poi; her father it was who urged that his children should have the best schooling, above all that the oldest daughter should run and play and work, ride, and swim just as did the other five.

When a twin of the oldest sister died in infancy her name, Mabel, had been given to the next child who came into the family, a year and a half later. Closer friend even than twin, this second Mabel has proved to the older sister. Always the two worked and played together, each aiding the other; always in the same class at school, Mabel reading lessons aloud at night, Eva quickly solving arithmetic and algebra problems for both and all the younger children as well! It may be that this lifelong custom of reading aloud was one source of the low, clear tones of voice which were habitual with Mabel Smyth. Surely the lifelong habit of thinking and planning and doing for the older sister helped to build up in Mabel the reserve of strength and gentleness, of forethought and decision on which all of her friends came to rely only too greatly. And all through her life there rippled a quick and often sparkling sense of fun. Whether from Celtic father or Polynesian mother, perhaps from both, there came also the trait of apparently unhurried leisure which marked her busiest hours and days.

Mabel Smyth's professional life would make a study in itself. From earliest childhood she longed to be a nurse. She was quick to acknowledge the aid of her Kona pastor, Rev. Albert S. Baker, in introducing her to the director of Palama Settlement in Honolulu, Mr. James A. Rath, in whose family she very soon began work as part-time helper. Mr. Rath must have seen almost at once the possibilities of development under systematic training. Later she worked with him for years at Palama and always with steady, unswerving loyalty.

In April of 1911, when Mr. and Mrs. Rath went to the mainland, Mabel Smyth had an opportunity to make the journey with them as nurse for their children. Her goal was a nurse's training at the Springfield Hospital Training School for Nurses in Massachusetts. She was only nineteen years old and far from home for the first time. The four years in Springfield were not easy ones. When homesick letters sometimes came back to Honolulu, her sturdy Hawaiian mother would always reply, "*Hoomanawanui,*—Have patience." With a new friend in Springfield, Mrs. Fred D. Williams, Mabel found a kind welcome and second home. As a graduate nurse she was without funds for her return to Honolulu, but her tools were ready. Several months' duty as private nurse soon met that need.

In 1915 Mabel Smyth joined the staff at Palama Settlement where her sister Julia, Mrs. David Desha, was already secretary to the director. For two years Mabel served as district nurse in Kalihi-kai, recalling her native tongue, making acquaintance again with her own people and with the many other racial groups affording her an unusual proficiency in the pidgin English which is so baffling to strangers and may almost be termed the universal language of Hawaii. During the absence of Miss Lucy Ward in 1916-18 Mabel Smyth took over the direction of the Hawaiian Humane Society, at that time organized for the care of children as well as animals.

On December 1, 1918, Mabel Smyth returned to Palama Settlement as head nurse, and continued there for nine years, until her thirty-fifth birthday, September 1, 1927. Of her initiative and executive ability, her quiet wisdom, her gracious dignity, in short, her human understanding in the development of this work, even the most judicious of her friends and critics are outspoken in admiration. It is not known that she ever made any enemies.

During the war Mabel Smyth signed up and worked with the American Red Cross. She hoped for duty overseas, but the armistice intervened.

She was granted a leave of absence in 1921 for work in Public Health at Simmons College in Boston. Thus came the long-sought opportunity to take her sister Eva for a year's work at the Perkins Institute for the Blind in Watertown, Massachusetts.

From 1922-27 Mabel Smyth introduced in Honolulu modern methods in public health nursing. She kept in close touch with developments on the mainland, going more than once as delegate to conferences and making frequent visits to the best centers for observation. In 1927 she was appointed director for the Department of Public Health Nursing in the Territorial Board of Health. Palama Settlement was reluctant to let her go but, all things considered, it was the logical course to pursue.

Up to that time there had been no generalized public health nursing for the territory under the Board of Health, Palama Settlement having been the pioneer in a similar service for Honolulu. Two branches of nursing, those for Tuberculosis and Maternal and Infant Hygiene, which had made beginnings, were now merged under Miss Smyth's direction into a very actively functioning department of generalized Public Health Nursing. For the first time, this service was also extended to include organization of generalized public health nursing under trained supervisors in the communities of rural Oahu and the outside islands.

When in 1929 Dr. Ira V. Hiscock, of the Public Health Department of Yale University, recommended a pooling of the Honolulu public health nursing services at Palama and in the Board of Health, with a view to prevent overlapping and to increase efficiency, Miss Smyth set her hand at once to the complicated task of arranging plans and schedules for perfecting the reorganization. On his return to the Islands, six years later, Dr. Hiscock expressed surprise at the rapidity and completeness with which this rearrangement had been effected.

In fact, wherever it was a matter of nursing or public health one could count on finding Mabel Smyth there as a progressive thinker and worker. She was for ten years, from 1925 to 1935, a very active member of the Board of Registration of Nurses, securing territorial cooperation before unobtained in that connection. Her thoughts were logical, her understanding intuitive and clear, her words cogent. The whole territory came to look toward her for authority and for steady, friendly counsel.

Her staff recalls her as President of the City & County of Honolulu Nurses' Association, trustee of the Territorial Nurses' Association, and member of the Nursing Service Board. An advisor to The Queen's Hospital Alumnae Association, she was constant in her influence toward maintaining high standards of training and technique. She was also a member of the Hawaiian Civic Club and among the first to advocate the establishment of a course in public health nursing at the University of Hawaii.

Quietly and without publicity Miss Smyth's constructive care in the growth of her own department has made her share in the work of the Board of Health a matter of history. Her staff of nurses increased from 24 in 1927 to 46 in 1936. Suddenly left without her, that staff squared its shoulders and carried on in her name.

All America acknowledges with pride the Jane Addams of Chicago. Surely it is not untimely, nor unseemly, to recall here the privilege of having known the Mabel Smyth of Hawaii, and to record here the inescapable longing that she might have continued among us another twenty, or even ten, years. She had achieved so much in the short span allotted her. Jane Addams and Mabel Smyth had not a little in common, and, as it chanced, were well acquainted. On her one visit to Oahu Miss Addams remarked to a mutual friend, "What a beautiful woman Miss Smyth is! With such charm of voice, too, and of manner. And her work is distinguished."

ETHEL M. DAMON

THE CIVIL DEFENSE COMMITTEE OF THE TERRITORIAL NURSES' ASS'N REPORTS:

DISASTER! One shudders at the possibility of any kind of disaster—whether personal or national. Yet, DISASTER can happen in any form: tidal wave, earthquake, or nuclear warfare. In meditating upon this subject, we'd like to think of man awakening from his apathy and doing something to prevent any major tragedies. We read, in this magazine and in that paper, about all kinds of life insurance policies to assist an individual personally. But what are we doing about assurance to assist one nationally?



SISTER M. LAURINE

The Territorial Nurses' Association has a committee which has been working at all odd hours to set up an educational program for its members. The committee met with the Directors of Nursing from various hospitals and won their support to launch the proposed program. It is interesting to note that eight agencies are participating in the instructor-trainee course at present.

Col. Daisy McCommons, of Tripler Hospital, and her staff graciously agreed to teach potential civilian instructors who in turn would conduct programs throughout the islands in the next two years until every nurse had been "exposed," so to speak.

Hence, the instructor-trainee course has been underway. Hospital faculty, supervisors in medical and surgical nursing, clinical instructors, instructors in Nursing Arts, etc., have volunteered to participate in this worthwhile project. From March 13 to May 8 nurses attended classes in the "Care of Mass Casualties" every Wednesday afternoon in the Conference Room at Queen's Hospital. Preparations for summer courses on Oahu are now under way.

It is of importance and interest to note that the "Care of Mass Casualties" has met with the approval of the Territorial Civil Defense Committee under the direction of Dr. Lee. In fact, this program will be supported financially by the Territorial Committee when the Nurses' Association is ready to conduct classes on neighbor Islands. The Medical Profession has likewise expressed approval.

The contents of the training program are as follows:

SUBJECT	TIME ALLOTMENT
Operating Room Technique	6 hrs.
Care of Burns	6 hrs.
Shock Ward Set Up	3 hrs.
Care of Wounds	9 hrs.
Casualty Deliveries	3 hrs.
Mass Evacuation	3 hrs.
Decontamination–First Aid	3 hrs.
Venipuncture	3 hrs.

The above is the material as covered by the staff from Tripler Hospital; the following will be conducted by the Territorial Committee on Civil Defense in the near future.

County Civil Defense Organization and Functions	2 hrs.
Evacuation of the Population; Evacuation Area SOP*	4 hrs.
Principles Involved in Management of Mass Casualties	2 hrs.
Casualty Stations in Atomic Disaster (SOP)	2 hrs.
Hospitals in Atomic Disaster (SOP)	2 hrs.
The 200-Bed Emergency Hospital	2 hrs.
Nursing Womanpower in Atomic Disaster (SOP)	2 hrs.

* Standard Operating Procedure.

SISTER M. LAURINE
NATH Civil Defense Committee

District and Section News

KAUAI:

President: Mrs. Pauline Johnson
Wilcox Memorial Hospital
Lihue, Kauai
Secretary: Mrs. Nobuko Hayashi
Mahelona Memorial Hospital
Kealia, Kauai
Date of Meeting: First Monday of the month.
Time: As announced.
Place: As announced.

HAWAII

President: Miss Eunice Graham
Puumaile Hospital
Hilo, Hawaii
Secretary: Miss Moira Wilson
Box 682
Hilo, Hawaii
Date of Meeting: First Tuesday of the month.
Time: 8:00 P.M.
Place: As announced.

OAHU

President: Mrs. Hazel Kim
St. Francis Hospital
Honolulu, Hawaii
Secretary: Miss Katsuko Takiguchi
Territorial Hospital
Kaneohe, Oahu
Date of Meeting: First Monday of the month.
Time: 8:00 P.M.
Place: Mabel Smyth Memorial Building

MAUI

President: Mrs. Michie Kamitaki
Department of Health
Wailuku, Maui
Secretary: Mrs. Lorraine Arakaki
Central Maui Memorial Hospital
Wailuku, Maui
Date of Meeting: Third Thursday of the month.
Time: As announced.
Place: As announced.

Semi-Annual Report of the Public Health Nurses Section of NATH

One executive committee meeting of the NATH PHN Section has been held since the 1956 Convention. This was on October 25, 1956. Two hundred dollars was granted to the Section from the NATH Board. It was agreed and executed that $25 would be sent to ANA for participation in the Runzheimer Transportation Study for the FSQ Committee. This report was received one month later and given to the Chairman, Miss Tamashiro, of the FSQ Committee.

Since Frances Nakamura, now on the mainland, could not continue as member-at-large of the Executive Committee, this committee elected Miss Yamana of Hawaii in her place. However, shortly after her appointment, she too left for the main-

land and Lily Saito of Hawaii was appointed. Hope this isn't catching!

A Public Relations Committee was created to facilitate or supplement the FSQ Committee, should their report be ready for publication in September. This committee will explore introduction of Minimum Standards of Employment Practice to our membership, the public, and current and prospective employers. Mrs. Marion Kwock is chairman and Emilia Centeio, Dorothy Tong, Kimi Tamashiro and Kazue McLaren are members. In conjunction with this we hope the membership of the section on all Islands is being kept informed on the progress of the FSQ Committee as the minutes are being circulated.

The Executive Committee requested Miss Peterson, then Chairman of the NADO PHN Section, to bring to the membership the problem of financing delegates to the 1957 Convention on Hawaii. This was duly done and a committee was formed at the Annual Meeting this January. Many fund raising projects are now under way.

The Model Form for Rules for PHN Section of State Nurses Association was received this month and forwarded to Mrs. Gloria Foster, of Maui, who is chairman of the Rules Committee.

The Functions Standards and Qualifications Committee of the PHN Section submits a progress report since the last Territorial Nurses Association Section meeting.

The committee has received the Runzheimer Report (re transportation allowances). The report has caught the attention of some of the Territorial offices as well as the Hawaii's Employers Council Research Department where they are on loan for study and evaluation.

The members of the Executive Committee of the National PHN Section have sent their comments through Miss Wallin on the FSQ Report, which was presented at the last Territorial Nurses Section Meeting and on the "Questions" concerned with some of the aspects of setting up standards and implementing their uses. The individual remarks are interesting, varied, and provocative, yet reassuring to the local FSQ committee that its ideas are progressive and in the right direction. It indicates, however, that much more study in breadth and depth need be made in setting up workable minimum standards for PHNurses.

GRACE H. SMITH

KAUAI

The Kauai Nurses Association celebrated the twenty-fifth anniversary of its founding with a banquet Thursday evening, March 14, at the Wilcox Memorial Hospital nurses' home. About 50 persons attended, including nine of the 31 living charter members. The association was organized in 1932 with 34 charter members.

Charter members present for the silver anniversary were Miss Mabel Wilcox, the first president; Miss Thelma Hensley; Mrs. Claire Carra; Mrs. Ann Clapper; Mrs. Miyoko Ednaco; Mrs. Josefina Cortezan; Mrs. Lillian Yamada; Mrs. G. M. Coney; and Mrs. Doris Hiramoto.

Brief biographies of most of the living charter members had been obtained and these were read by association members. Some of the charter members are still active in nursing.

The charter members had messages of congratulations and encouragement for the association. Special honors went to Miss Wilcox.

Mrs. Pauline Johnson, association president, opened the dinner gathering. Miss Elizabeth Middleton was mistress of ceremonies. Hawaiian music was provided by the practical nurses.

Arrangements for the anniversary celebration were by Miss Wilcox and Miss Hensley, nursing superintendent of Mahelona Memorial Hospital.

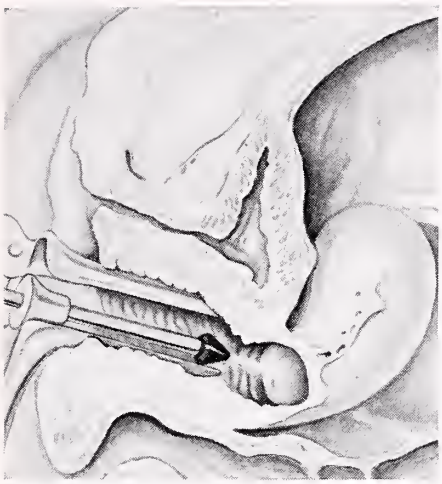
(MRS.) JOSEPHINE C. DUVAUCHELLE



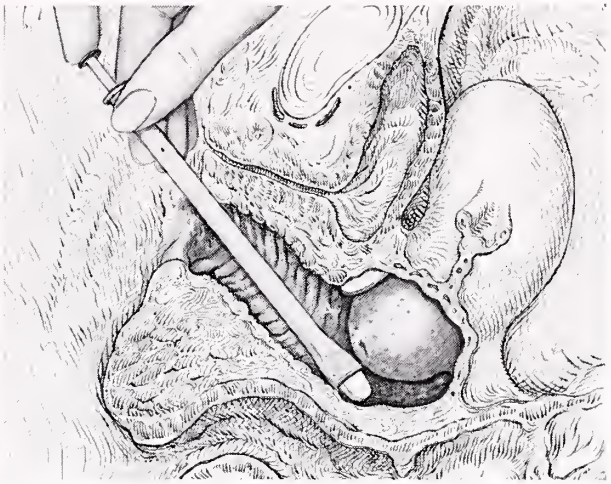
CHARTER MEMBERS AT KAUAI'S 25TH ANNIVERSARY BANQUET

Left to right: Thelma Hensley, Mrs. Claire Carra, Ann Clapper, Miyoko Ednaco, Josephina Cortezan, Mabel Wilcox, G. M. Coney, Lillian Yamada, and Doris Hiramoto.

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A Floraquin applicator is supplied with each box of 50 Floraquin tablets. G. D. Searle & Co., Chicago 80, Illinois, Research in the Service of Medicine.

*Williamson, P.: Trichomonad Infestation, M. Times *84*:929 (Sept.) 1956.

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1. Zintel, H. A.: *Surg. Clin. North America,* 36:257, Apr., 1956. 2. Freeman, B. S.; and Young, T. K., Jr.: *Arch. Surg.,* 61:1145, Dec., 1950.

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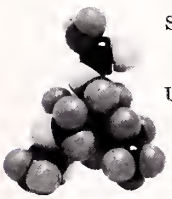
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1 "I have used meprobamate in my general psychiatric practice since April, 1955, and believe it to be [a] drug of choice for relief of tension, anxiety and insomnia."

Lemere, F.: Northwest Med. **54**: *1098, 1955.*

2 ". . . the patient [taking Miltown] never describes himself as feeling detached or 'insulated' by the drug. He remains . . . in control of his faculties, both mental and physical, and his responsiveness to other persons is characteristically improved."

Sokoloff, O. J.: A.M.A. Arch. Dermat. **74**: *393, 1956.*

3 "Of special importance is the fact that Miltown does not appear to affect autonomic balance—which in alcoholics is often unstable . . ."

Thimann, J. and Gauthier, J.W.: Quart. J. Stud. Alcohol. **17**: *19, 1956.*

4 "The [relative] absence of toxicity, both subjectively and objectively, is an important feature in favor of Miltown. In addition, there were no withdrawal phenomena noted on cessation of therapy, whether it was withdrawn rapidly or slowly."

Borrus, J.C.: J.A.M.A. **157**: *1596, 1955.*

5 "Miltown is of most value in the so-called anxiety neurosis syndrome, especially when the primary symptom is tension . . . Miltown is an effective dormifacient and appears to have . . . advantages over the conventional sedatives except in psychotic patients. It relaxes the patient for natural sleep rather than forcing sleep."

Selling, L.S.: J.A.M.A. **157**: *1594, 1955.*

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formerly **Ataraxoid**
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advantages: (1) greater flexibility of dosage (2) effective tranquilization permits lower corticoid dosage

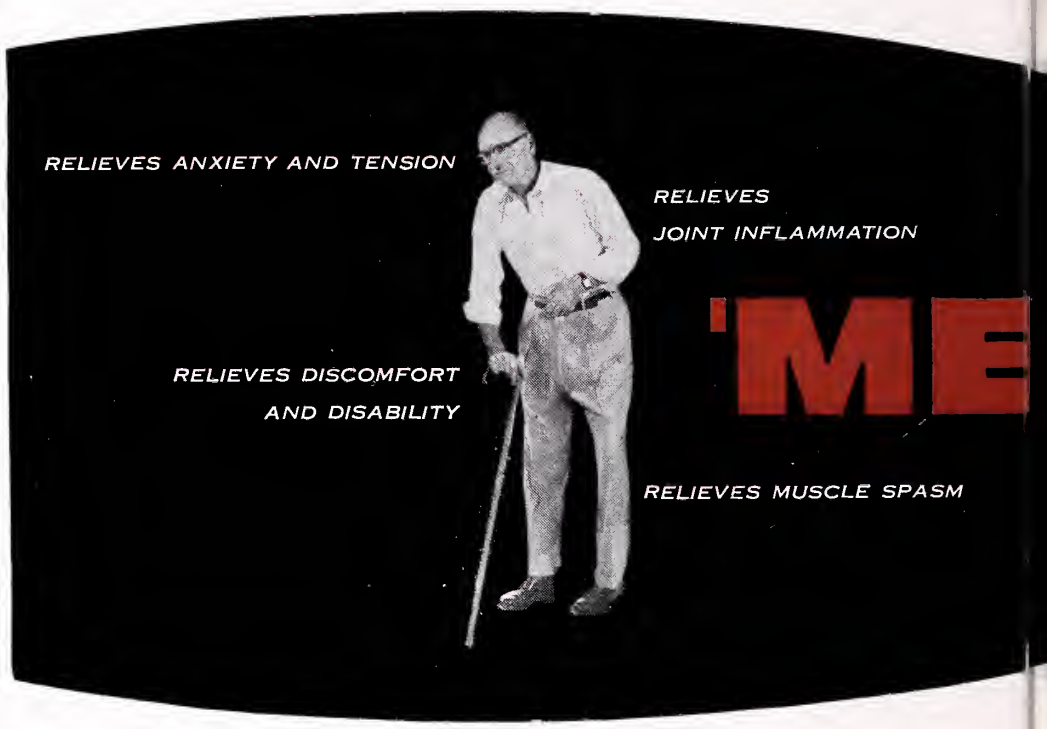
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arthritis, bursitis, synovitis, tenosynovitis, myositis, fibr sitis, fibromyositis, neuritis, acute and chronic low ba pain, acute and chronic primary and secondary fibrosi and torticollis, intractable asthma, respiratory allergi allergic and inflammatory eye and skin disorders (as ma tenance therapy in disseminated lupus erythematos periarteritis nodosa, dermatomyositis and scleroderm

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Literature available on request

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SIX MONTHS AGO, when Tom came down with tuberculosis, his friends feared that he would disappear from the world of the well to spend *years* in a hospital.

Those fears might have been justified some time ago. Now, fortunately, when cases like Tom's are discovered early, doctors can often restore good health without the long stay in a hospital, and all the attendant worries about the problems of finances, family and future.

Tuberculosis is still a great problem when diagnosis is delayed and the disease has progressed. But experts agree that medical science has surely gained the upper hand . . . through earlier detection, improved surgery and the anti-tuberculosis drugs. These advances have reduced tuberculosis from first to sixth place among the ten leading causes of death.

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As a maker of medicines prescribed by physicians, Parke-Davis is proud to be among those engaged in this great, world-wide fight against tuberculosis.

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Working with your physician, your pharmacist and your hospital to make modern medical care one of the most rewarding investments of your life.

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"Tom" had tuberculosis. And in this latest Parke-Davis message on the cost of medical care, "Tom's case" is used as a specific example of the heartening progress being made against sickness and disease.

The ad points out that, thanks to earlier detection, improved surgery and the anti-tuberculosis drugs, tuberculosis has fallen from first to sixth place among the ten leading causes of death.

Unfortunately, most people do not appreciate the priceless value of today's more effective medical care until they come face to face with a dread disease—like "Tom". And that's why, with a colorful new series of advertisements,* Parke-Davis is helping to give your patients a new and clearer understanding of what modern medical care can do for them—in terms of getting them well quicker, back on the job again, and even saving their lives.

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HAWAII

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COUNTY MEDICAL LIBRARY

(*Continued from page 542*)

Coburn, A. F. *Splenin A in rheumatic fever.* c1955. (gift of publisher)
Hewitt, R. M. *The physician writers' book.* c1957. (gift of publisher)
Keefer, C. S. *Prolonged and perplexing fevers.* c1955.
Montague, J. F. *How to overcome colitis.* c1956. (gift of publisher)
Pekelharing, C. A. *Beri-beri.* 1893.

* * *

We wish to acknowledge the gift of a *Manual of Therapy with the Meti-Steroids* from Schering Corporation, and also the *Atlas of Normal Anatomy* from Lederle Laboratories.

* * *

The Medical Library feels the loss of a great friend in the death of Dr. Frank L. Pleadwell, an honorary member. Dr. Pleadwell served on the Library Committee for several years, and was influential in establishing policies which directed the development of the collection and promoted its rapid growth. Moreover, he was always a most generous contributor of his own medical books and journals, and gave us discerning counsel on book selection and other literary matters.

The Library Board has decided to have a bronze plaque designed in Doctor Pleadwell's memory. This will be placed in the new library, near the medical history section, since this was the field to which he devoted so much time and effort.

PERHAPS IT'S YOUR NERVES

(*Continued from page 541*)

tional rehabilitation, alcoholism, veterans' affairs, and other governmental resources.

All in all, it is important to note that the cooperative teamwork of many agencies and persons is necessary for total care of the patient and his family. The large-scale cooperative attack on tuberculosis is an excellent example of what can be done by cooperative teamwork and enlightened investment of time and money in a health program. A similar trend is now being demonstrated in the field of mental illness in many states. One of the most important reasons that this has come about seems to be that both the general public and professional persons are becoming more accurately informed about personality disorders and the various approaches to prevention and treatment. Increased understanding is leading to increased appropriate action.

ROBERT A. KIMMICH, M.D.

WOMAN'S AUXILIARY

(*Continued from page 551*)

ness meeting and a ten minute movie, Danger at the Source, about medical schools and their financial needs, was shown.

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DESERVES
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(*Continued from page 550*)

MEETINGS (Continued)

Idaho

Idaho State Medical Association—Annual Meeting—Sun Valley—June 16 to 19

Illinois

The Neuromuscular Diseases of Children with Special Emphasis on Cerebral Palsy—Chicago—July 8 to 19

The World Medical Association, Medicine—A Life Long Study—Chicago—August 30 to September 4

Annual Assembly in Otolaryngology, University of Illinois College of Medicine—Chicago—September 30 to October 6

Nevada

Nevada State Medical Association, Annual Meeting—Las Vegas—September 25 to 28

New York

New York University, Management of Chronic Kidney Disease—New York—June 24 to 25

New York University, Management of Hypertension—New York—June 26 to 27

Tennessee

Institute of Nuclear Studies Seminars on Thyroid-Uptake Measurement—Oak Ridge—March 18 and 19, April 15 and 16, May 17, and June 10 to 14

Texas

American Fracture Association 18th Annual Meeting—El Paso—September 30 to October 3

Wyoming

Wyoming State Medical Society Rocky Mountain Medical Conference—Moron—June 16 to 19

Washington, D. C.

5th Symposium on Antibiotics—Willard Hotel—October 2 to 4

World Congress of Gastroenterology—May 25 to 30, 1958

Miscellaneous Meetings

Biological Photographic Association, Inc.—Rochester, Minnesota—August 27 to 30

Foreign

Canada

The Ninth International Congress on Rheumatic Diseases—Toronto—June 23 to 28

England

International Congress on the Circulation—London—June 3 to June 8

International Cancer Congress—London—July 6 to 12, 1958

Switzerland

Fourth International Poliomyelitis Conferences—Geneva—July 8 to 12

Thailand

Ninth Pacific Science Congress—Bangkok—November 18 to December 9

Turkey

World Medical Association—General Assembly—Istanbul—September 29 to October 5

AMA Meetings

December 3 to 6, 1957—Philadelphia
June 23 to 27, 1958—San Francisco
December 2 to 5, 1958—Minneapolis
June 8 to 12, 1959—Atlantic City

BOOK REVIEWS

(*Continued from page 543*)

section entitled "On how to be a good dermatologic therapist without being a particularly good dermatologic diagnostician." The rest of the book is rather catholic in nature but highly informative although too many rare and unusual things are gone over far beyond the needs and desires of pediatricians to know.

C. V. CAVER, M.D.

Paper Electrophoresis.

By G. E. W. Wolstenholme and Elaine C. P. Millar, Ciba Foundation Symposium, 224 pp., illus., Price $6.75, Little, Brown and Company, 1956.

In keeping with the excellence of previous Ciba Foundation Symposia, this little book of 224 pages presents original papers and critical discussions by outstanding workers in the field of paper electrophoresis. This procedure has become increasingly important as a diagnostic aid in medicine and has already attained the status of a necessary tool in our laboratories. Although much of the material in this volume is highly technical, it should be of great interest to pathologists and clinicians alike.

T. F. FUJIWARA, M.D.

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Joint Ligament Relaxation Treated by Fibro-osseous Proliferation.

By George Stuart Hackett, M.D., F.A.C.S., 97 pp., Price $4.75, Charles C. Thomas, 1956.

The reviewer of this unindexed booklet of less than one hundred pages has made an honest effort to find something favorable to report about it with little success. In the first place he finds the physiological principle upon which it depends, i.e. the use of "proliferating solution," has long since been outmoded and discarded as a therapeutic agent by all except those surgeons practicing, one might say, in the twilight zone.

The book is loosely put together as regards chapter divisions and not one definite reference is given in the bibliography of almost fifty articles and books. It implies that such men as Badgley, Barr, Lowman, Magnuson, Ober, Shands, Steindler, Ghormly, and others give approval to the misleading and erroneous statements made.

The sale of the book, it is hoped, will not be too extensive, but it is feared that it will give authority to unscrupulous, poorly trained physicians to practice an abandoned type of surgery. One is surprised that a publishing house undertook to put it on the market. The sooner it is forgotten, the better.

J. Warren White, M.D.

Cytology of the Blood and Blood-Forming Organs.

By Marcel Bessis, 629 pp., illus., Price $22.00, Grune & Stratton, 1956.

This is a very learned treatise on cells which goes into complicated chemistry, electronmicroscopy, and phase microscopy in addition to the usual cytologic studies. Experimental procedures and theories are discussed. It is an excellent treatise for an experimental hematologist and a valuable reference for clinical hematologists and pathologists. Classification may be a little foreign to American readers. The book deals not at all with aspects of therapy, however, but is not intended to do so. It is certainly a pioneer in exploring the newer horizons of hematologic cytology. References are adequate. Physically, the book is well illustrated, easily read, and well bound.

W. Harold Civin, M.D.

Cardiac Diagnosis, A Physiologic Approach.

By Robert F. Rushmer, M.D., 447 pp., W. B. Saunders Company, 1955.

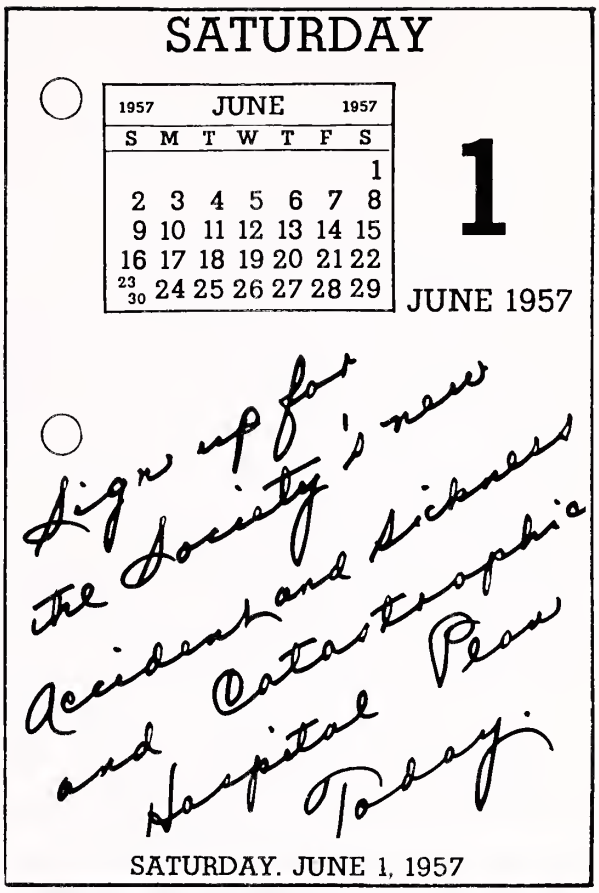
The chief value of this comprehensive volume on cardiac physiology is contained in the illustrations. The diagrams of various aspects of the circulation are excellent. The explanation of the Fick principle, for instance, is very clear.

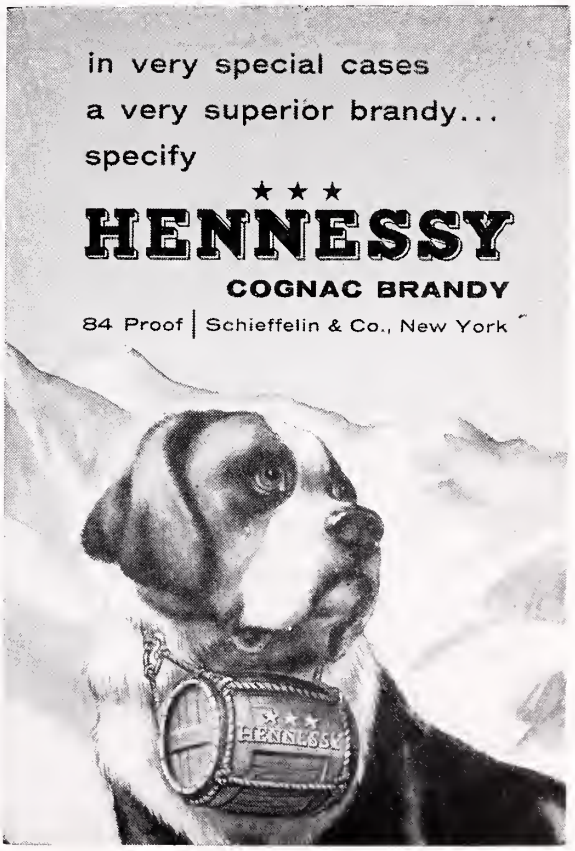
One finds the text, however, heavy and wordy. One feels that the author hesitates to leave out anything remotely related to his subject. In vain does one search for a pithy phrase or well-remembered short sentence, such as Sir Thomas Lewis' "Pulsus alternans tolls the knell of parting day," or William Boyd's "Rheumatic fever licks the joints but bites the heart."

It is said one picture equals one thousand words—all are presented here.

Alfred S. Hartwell, M.D.

(*Continued on page 588*)







SURGEONS WITH

"THE FEATHER TOUCH"

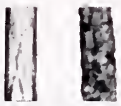
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Potts, W. J.: J. A. M. A. 157:627 (Feb. 19) 1955, p. 627.

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Advancing with surgery

(*Continued from page 546*)

of HMSA; Albert Yuen, assistant secretary of HMSA; and James Carroll, manager of the Hilo branch. Dr. A. Webster Boyden, the president of the Hawaii Medical Association was also a guest and making his official visit to our society.

A business meeting was conducted at 7:55 P.M. by President Mitchel. (1) The application of Dr. Goichi Asami for membership into the Society was unanimously approved. Dr. Asami is a graduate of the Washington University School of Medicine in 1920 and has opened his practice in Kealakekua, Kona, Hawaii. (2) Discussion on the Board of Health's request for assistance at a clinic for free Salk vaccine injections for individuals up to the age of 20 and pregnant women was acted upon. It was moved by Dr. Walter Loo, seconded by Dr. Ted Oto, and approved that this society sponsor a Polio Clinic for free Salk vaccine with the assistance of the Board of Health and the Polio Foundation.

After dinner, a general and well planned discussion of HMSA was conducted by talks given by Mr. Ralph Beck on the organization and problems of HMSA, a discussion and illustrated talk on the make-up of the HMSA Board of Directors by Mr. Albert Yuen, and a discussion by Mr. Veltmann on the Community Group Plan and the possibility of increasing its rates with full payment to doctors, the changing of the income clause, and the fact that the final decision rested with the medical societies.

Dr. Boyden, president of HMA requested (1) the name of the new president, (2) the name of the chairman of the legislative committee, (3) names deemed suitable for Merit Awards to be presented by the HMA, (4) a lay representative to the Board of HMSA and suggested someone connected with the medical fraternity; he suggested the executive secretary of the Honolulu County Medical Society and in this regard, Dr. Orenstein so moved and Dr. Woo seconded and the society approved unanimously such an action, (5) that this Society name one standing committee to handle grievances of the Medical plan, (6) that we exercise care in selecting our delegates and the HMSA representative. He announced the annual meeting of the HMA in Kauai in May 1957.

A short discussion of the HMSA acting as the intermediary for the Veterans Home Town Care Program was held. Dr. Willett moved, Dr. Loo seconded, and the society unanimously approved that HMSA continue as intermediary for the Veterans Home Town Care Program and that we approve the Medicare fee schedule for VA cases.

* * *

The annual meeting of the Hawaii County Medical Society was a dinner meeting held at the Country Club on March 23, 1957, with twenty-one members present and Dr. Chong as guest.

A report from the polio inoculation committee was given by the chairman, Dr. Miyamoto. His committee consisted of: Drs. Bergin, Loo, Okumoto, and Woo. Their recommendations were as follows: Polio clinics will be advertised stating acceptance of anyone who has not had polio vaccine up to and including nineteen year olds and pregnant women. However, anyone with incomplete polio immunization in the above categories would be accepted if they came to the clinic.

Drs. Yuen and Orenstein were appointed incoming delegates to the territorial HMA meeting to be held in May. Alternates named were Drs. Woo and Mitchel.

Dr. Mitchel pointed out the need of establishment of a third membership status in our society. At present we have the regular and honorary status. Dr. Woo made a motion to have the legislative committee study changing the bylaws to create a third status. Dr. Crawford moved that the above motion be amended to state that the legislative committee should consider changing the date of election and the annual meeting. It was seconded by Dr. Okumoto. Dr. Kasamoto made another motion which was seconded by Dr. Crawford that it be amended that the legislative committee also establish the minimum attendance of the regular county society meetings. The original motion by Dr. Woo and its amendments were passed unanimously.

A report by the nominating committee consisting of Drs. Okumoto, M. H. Chang, Crawford, and Yuen was read by Dr. Mitchel:

President	Dr. Miyamoto
Vice-President	Dr. Okada
Secretary	Dr. Yamauchi
Treasurer	Dr. Helms
Censor	Dr. Steuermann

Doctor Orenstein moved that the nominating committee report be accepted. It was seconded by Dr. Okumoto and unanimously passed. After his acceptance speech, Dr. Miyamoto presided over the remainder of the meeting as the new president.

KAY K. OTA, M.D.
Secretary

Honolulu

A joint meeting of the Honolulu County Medical Society and the Honolulu County Dental Society was held March 5, 1957, with Dr. Nishigaya presiding. Approximately 150 physicians and dentists were present.

Dr. Nishigaya welcomed the dentists on behalf of the Medical Society and called upon Dr. Alexis Burso, President of the Dental Society, who introduced their officers and then thanked the Medical Society for being invited to participate in the program. He also expressed the hope that there would be more opportunities for such meetings in the future.

A symposium, Early Detection of Cancers, was held. Dr. Quisenberry served as moderator. Participants were J. M. Marnie, D.M.D., Perry H. Wilson, D.D.S., Albert K. T. Ho, M.D., and Grover H. Batten, M.D.

A movie, Oral Cancer, was shown, followed by a question and answer period.

Announcement was made at the beginning of the meeting that the program would be interrupted with the arrival of Dr. Dwight Murray, President of the American Medical Association. He is on a tour of the Pacific and Far East to inspect military medical facilities and had consented to address the membership. Upon his arrival, Dr. Murray was introduced by Dr. Samuel Yee who on behalf of the County Medical Society expressed his pleasure and honor in having him present. Dr. Murray's remarks were both timely and pertinent, touching on such subjects as fluoridation, cancer, Salk Vaccine and the Medicare program. Dr. Leo H. Bartemeier, Chairman of the AMA's Council on Mental Health, who is accompanying Dr. Murray, was also asked to speak.

Following the panel discussion, the dentists adjourned to the lounge for a short business meeting of the Dental Society.

A short business meeting of the membership was held. The president informed the membership of attending a meeting with Mr. Kennedy on Maluhia's plans to convert to a general hospital. A spirited discussion followed.

(*Continued on page 580*)

COUNTY SOCIETY REPORTS

(*Continued from page 579*)

Information was also given on the AMA and National Polio Foundation's plans to inoculate everyone from 20 to 40 against polio. Plans are being formulated locally and the Public Service Committee is looking into the matter for the Medical Society.

The meeting was then adjourned to the lanai, where refreshments were enjoyed.

* * *

A joint meeting of the Honolulu County Medical Society and the Hawaii Bar Association was held April 2, 1957, at 7:30 P.M., in the Mabel Smyth Auditorium. Approximately 205 doctors and lawyers were present.

Dr. Nishigaya opened the meeting and thanked the legal profession for their part in bringing the two professions closer together. He then introduced Mr. Ralph Yamaguchi, President of the Bar Association, who spoke briefly on the newly formed Medical-Legal Committee and acquainted the audience with the work and aims of the committee.

An outstanding film, *"The Medical Witness,"* was shown, preceded by introductory remarks made by Judge Luman N. Nevels, Jr., of the Third Circuit Court.

A panel discussion on the Hypothetical Question, Testimony and Conduct as Witnesses in Court by Doctors, was held with Ronald B. Jamieson serving as moderator. Panel members were Mr. John F. Alexander, Mr. William Cobb, Mr. Thomas Waddoups, Dr. Harry Arnold, Jr., Dr. Ralph B. Cloward, and Dr. Alvin C. Majoska.

An open forum discussion followed, with the audience participating freely.

The meeting was then adjourned to the lanai where refreshments were enjoyed by all.

T. NISHIGAYA, M.D.
President

Kauai

The regular meeting of the Kauai County Medical Society was called to order on Tuesday, February 5, 1957, at 7:35 P.M. at the Wilcox Memorial Hospital Library by Dr. Wallis, Secretary, in place of Dr. Wade, who was attending a meeting of the wives of doctors at Dr. Cockett's for the purpose of organizing a Woman's Auxiliary.

Members present: Drs. Boyden, Fujii, Goodhue, Ishii, Kim, Kuhlman, Kuhns, Masunaga, Wade and Wallis. Visiting: Dr. Winter.

First item of the program was a film, shown by Don Higgins of Parke Davis & Co., entitled "Going My Way."

A letter from Dr. Ralph Cloward was read regarding his holding a clinic on Kauai every third Wednesday of the month and also for operations when indicated. No action was taken on the letter.

A letter from the Citizens' Pure Water Committee was discussed by Dr. Wade. No action taken.

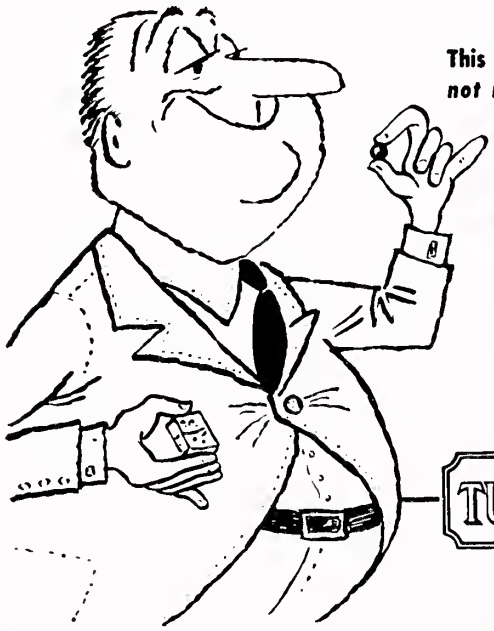
A letter from Miss Lee McCaslin regarding the Veterans' Home Town Care Program was read. The subject of the letter was regarding the Veterans' Fee Schedule. It was moved by Dr. Goodhue and seconded by Dr. Fujii that the fee schedule be the same as that of the Medicare Program of the service dependents. Passed.

Another letter was read from HMSA regarding Community Group Medical Plan. The usage on Kauai has been quite satisfactory and there was to be a refund for the last six months period. No action taken.

The following were appointed by Dr. Wade for the HMSA Medical Committee:

Delegate	Dr. Kuhlman
1st Alternate	Dr. Brennecke
2d Alternate	Dr. Kim

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It was moved by Dr. Boyden and seconded by Dr. Kuhns to approve these appointments. Passed.

Dr. Brennecke was appointed Program Chairman for the coming year.

Free polio shots were discussed. Apparently, Kings County, New York, started giving free polio shots and it has been started at quite a number of other localities on the mainland. It was moved by Dr. Kuhlman that free polio vaccine inoculations be given to people from age 1 to 19 provided the vaccine is furnished free and that it be given at Health Service Centers or any other designated service centers in the island. This motion was seconded by Dr. Masunaga and passed. Dr. Wallis is to contact the Board of Health and report at the next meeting of the results.

The remainder of the meeting was turned over to Dr. Wade to discuss the coming HMA meeting to be held in May. No definite action taken by committee on any definite subject.

* * *

The regular meeting of the Kauai County Medical Society was called to order on Tuesday, March 5, 1957, at 7:35 P.M. at the Wilcox Memorial Hospital Library by Dr. Wade.

Members present: Drs. Wade, Kuhlman, Cockett, Masunaga, Boyden, Ishii, Kim, Goodhue, Kuhns, Fujii, Wallis.

Dr. Masunaga was elected by secret ballot to fill the office of vice-president left open by Dr. Schilling, who took residency on the mainland.

Dr. Wallis brought up the subject of having a third year medical student working under him under preceptorship. There was some discussion of this matter and it was moved by Dr. Boyden and seconded by Dr. Cockett that Dr. Wallis be allowed to have this third year student work under him during the summer.

Dr. Boyden reported that if there are any problems with the Medicare program, that these problems should be brought up to the HMA before April 1 as new contract will be negotiated sometime after that date. He also reported that the Kauai County Medical Society is the only county medical society that does not pay the delegate's transportation and maintenance at the annual meeting. He also notified the society that the council member should be paid in the future by the HMA. It was also reported that the other county medical societies voted not to have the minutes of the meeting published in the JOURNAL.

Dr. Kuhlman brought up the subject of government physician and felt that the government physician's plight should be aired before the HMA. It was Dr. Kuhlman's idea that the HMA should study the indigent program and make a report as to what should be done about it rather than leave it up to the Board of Health. It was suggested that this matter be brought up at the next council meeting. No action was taken.

Dr. Kuhlman reported on the 1956 Diabetic Survey. He reported that out of 4,925 specimens received, there were 252 unknown positive specimens which is approximately 3%. However, he stated that some of the tests were questionable as some of the cases reported as positive were not positive on the recheck.

The meeting was adjourned at 9:15 P.M. and was followed by a tape recording on Differential Diagnosis of Coronary Heart Disease.

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(Continued from page 545)

Returning to Kyoto, Japan, he established the Saisei Hospital, a charitable hospital for the needy.

Dr. Kobayashi was well versed in literature and was especially good in Japanese ballads.

When he died suddenly on October 28, 1926, at the age of 63 in Kyoto, Japan, he left behind two institutions, which he had started, that had far reaching and lasting benefits for the sick and needy.

Henry Williams Howard

Henry Williams Howard was born in Marseilles, Illinois, in 1867.

He was educated at Mount Sharon Academy and at Rush Medical College, which granted him his M.D. degree in 1890. Almost immediately he was appointed clinical instructor in his alma mater in diseases of the eye and ear. Following this Dr. Howard went into private practice in Chicago for three years.

In May, 1893, he arrived in the Islands to accept the post of government physician on Kauai. After service there for a short time, Dr. Howard was called to Honolulu to become city physician.

During the cholera epidemic of 1895, he was one of the physicians placed in charge of the cholera hospital at Kakaako where he took upon himself the arduous task of night duty.

In 1903 Dr. Howard returned to Chicago to become superintendent of the Presbyterian Hospital. This position he held until 1906 when he resigned to become associated with Dr. Norman Bridge in Los Angeles. Until his retirement in September, 1926, due to ill health, he was honorary chief of staff of the Angelus Hospital in Los Angeles.

Dr. Howard died in Los Angeles on February 23, 1927, at the age of 60.

While in Hawaii, Dr. Howard was one of the prime movers in the organization of the Medical Society of Hawaii, serving as its vice-president for two years. Also he helped in the formation of the Practitioners' Club.

Saburo Hayashi

Saburo Hayashi was born on February 22, 1867, in Wakamatsu Shi, Aizu, Japan.

He received his M.D. degree in 1884 from Aomori Prefectural Medical College. Between 1885 and 1892 he studied in San Francisco and received his M.D. degree there.

In 1892 he came to Hawaii and established his practice in Kona, Hawaii, where he lived for the next forty years.

He was instrumental in starting the Kona Japanese School, Kona's weekly paper the "Kona Echo" in 1897, the Kona Japanese Society and the Kona coffee mill.

He was married to Miss Matsu Harada, and they had twelve children: Sansei, Chisato, Peter, Shigeki, Ensei, Jiro, Gilbert, Lillian, Elsie, Fusa, May, and Yuki.

In 1940 Dr. Hayashi received an official commendation from the Japanese foreign minister for the work he did among the Japanese in Kona. He died on June 4, 1942, in Kona at the age of 75, having spent his productive years serving the needs of the coffee growers.

Perley Johnson Aiken

Dr. Aiken was born in Tennessee about 1845, the son of a Presbyterian minister of Knoxville. He graduated from Jefferson Medical College, Philadelphia, in 1867.

When in 1874 he went to California, he lived in Virginia City. Later he was medical director at Yourtville, Napa County, for six years. While at Napa he heard that Paia, Maui, needed a doctor, so about 1894 he came to Paia where he practiced many years.

Dr. Aiken died at Paia on October 26, 1905.

A daughter, Mrs. Alexander Ball, lives at Wailuku, Maui. Another daughter, Mrs. Irene Staratt, lives in California. He is also survived by two sons: Worth lives in Berkeley, California, and George Aiken, D.D.S., resides in Palo Alto.

Harry Vicars Murray

Harry Vicars Murray was born June 5, 1867 at Pictou, Nova Scotia, the son of Angus and Jane (McKay) Murray. He was a descendant of Walter Murray of Sutherlandshire, Scotland, who settled in Pictou in 1773.

He received his preliminary education in Pictou and later attended Dalhousie University, Halifax. The University of New York granted him his M.D. in 1889. From the spring of 1889 to August, 1891, Dr. Murray worked at Chambers Street Hospital, Dewitt Dispensary and Roosevelt outdoor departments in New York. He then studied at Edinburgh and London until the fall of 1892.

From 1892 to September, 1893, Dr. Murray served on Canadian-Australasian liners.

In 1894 he settled in Honolulu and was first associated with Dr. Brodie. It was Dr. Murray who discovered the first case of cholera in the epidemic of 1895.

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Dr. Murray married Rose Cunha on June 5, 1905, at Honolulu. Two sons were born to the Murrays: Clarence Douglas and Richard, who died in infancy.

Leaving Honolulu June, 1917, Dr. Murray went to Canada where he was commissioned as captain in the medical corps. He went overseas with the Canadian Army Medical Corps and served as senior medical officer of the C.A.M.C. depot at Shornecliff, England. On going to France, he saw active service with the First Canadian casualty clearing station at the front and later with the Imperial 48th casualty clearing station. At the end of the war Dr. Murray was commanding officer in charge of all sick British prisoners of war as they were returned from German prison camps through the headquarters at Liege, Belgium. He returned to Honolulu September 23, 1919.

Dr. Murray died July 1, 1920, in San Francisco, at the age of 53.

He was past president of the Hawaiian Medical Society, past president of the Pacific Club, member of the University Club and the Country Club, and president of the British War Veterans' Society.

James Thomas Wayson

James Thomas Wayson was born June 16, 1870, at Port Townsend, Jefferson County, Washington, the son of Thomas and Mary (Riley) Wayson. He was descended from Colonial stock, his parental ancestors having settled in Maryland prior to the Revolution. His father was an engineer captain in the Coast Guard service, serving as chief engineer of the "Abraham Lincoln," the first steam revenue cutter to round the Horn.



DR. WAYSON

Dr. Wayson received his M.D. degree from the University of California in 1891. In 1892 he served as a house physician at Portland Hospital, Portland, Oregon.

The doctor's first professional appointment was surgeon on an American revenue cutter assigned to Alaska and the Bering sea. The mission was to collect data on seals for use at the Paris conference in 1893 which met to consider the protection of seals in northern waters.

Dr. Wayson's interest in Hawaii had been aroused by his grandfather who, from 1830 to 1850, was a New Bedford whaler and visited Hawaii many times. On the completion of his Alaska mission, he came to Hawaii, arriving November 25, 1894.

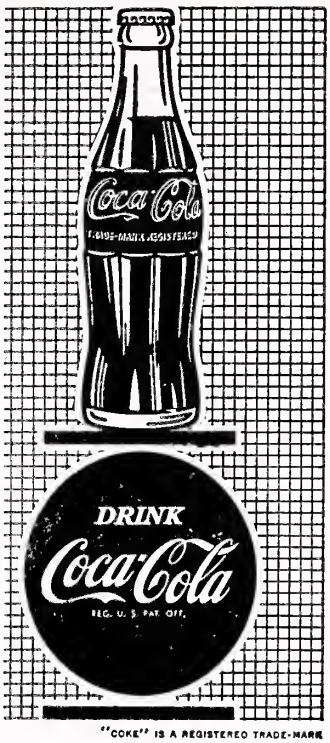
As a member of the old Hawaii National Guard, Dr. Wayson took part in the revolution of 1895 when the late Delegate Robert W. Wilcox headed the unsuccessful revolution to restore the ex-queen to the throne.

During the cholera outbreak of the same year, Dr. Wayson received the appointment of city medical inspector. In April, 1895, he was appointed attending physician at the Kalihi Receiving Station.

On November 25, 1897, Dr. Wayson and Delia Walcott Sheehy were married. The couple had two daughters, India (Mrs. Walter J. L. Wilson) and Eleanor (Mrs. Robert P. Stoat).

(*Continued on page 586*)

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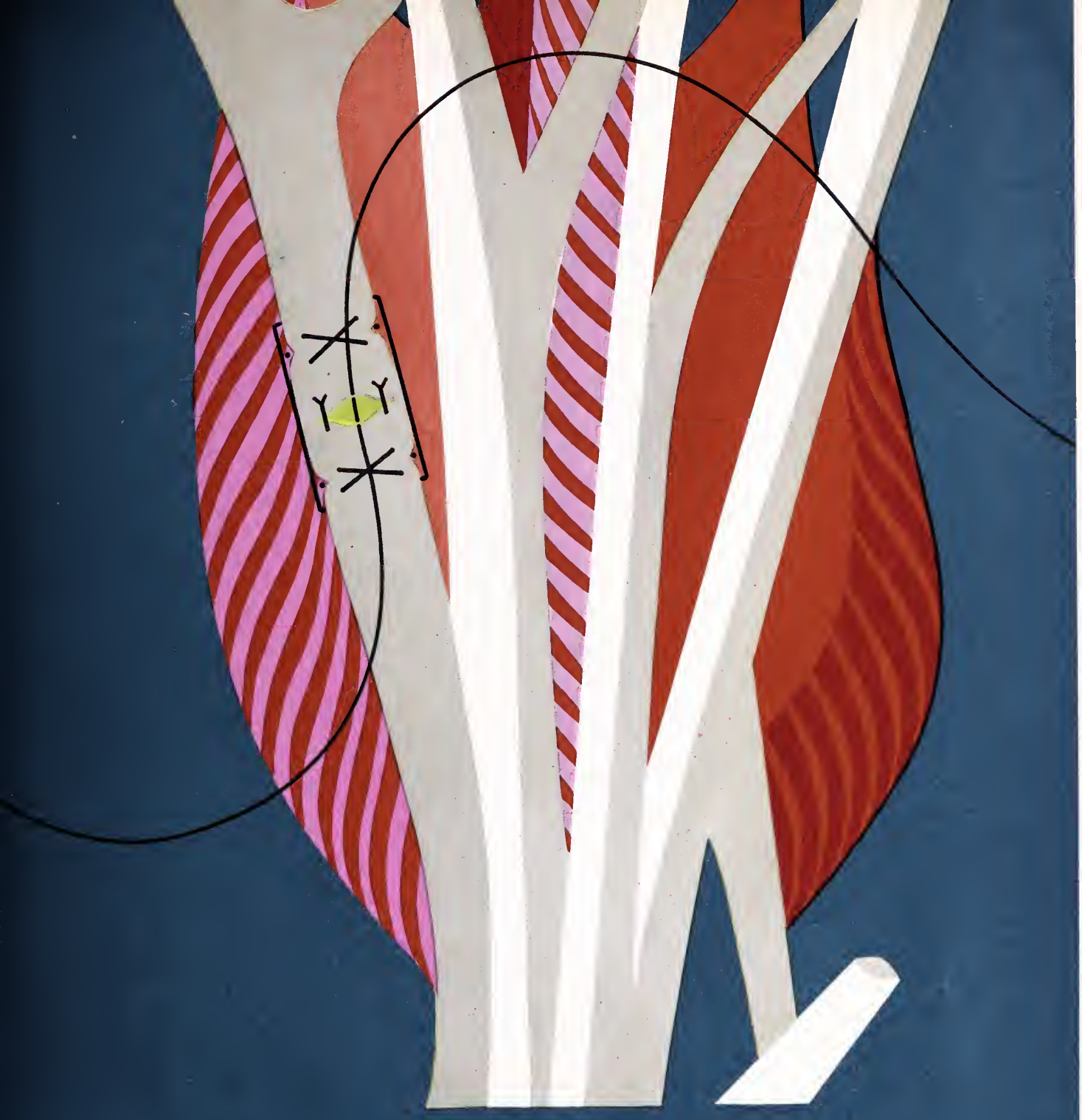
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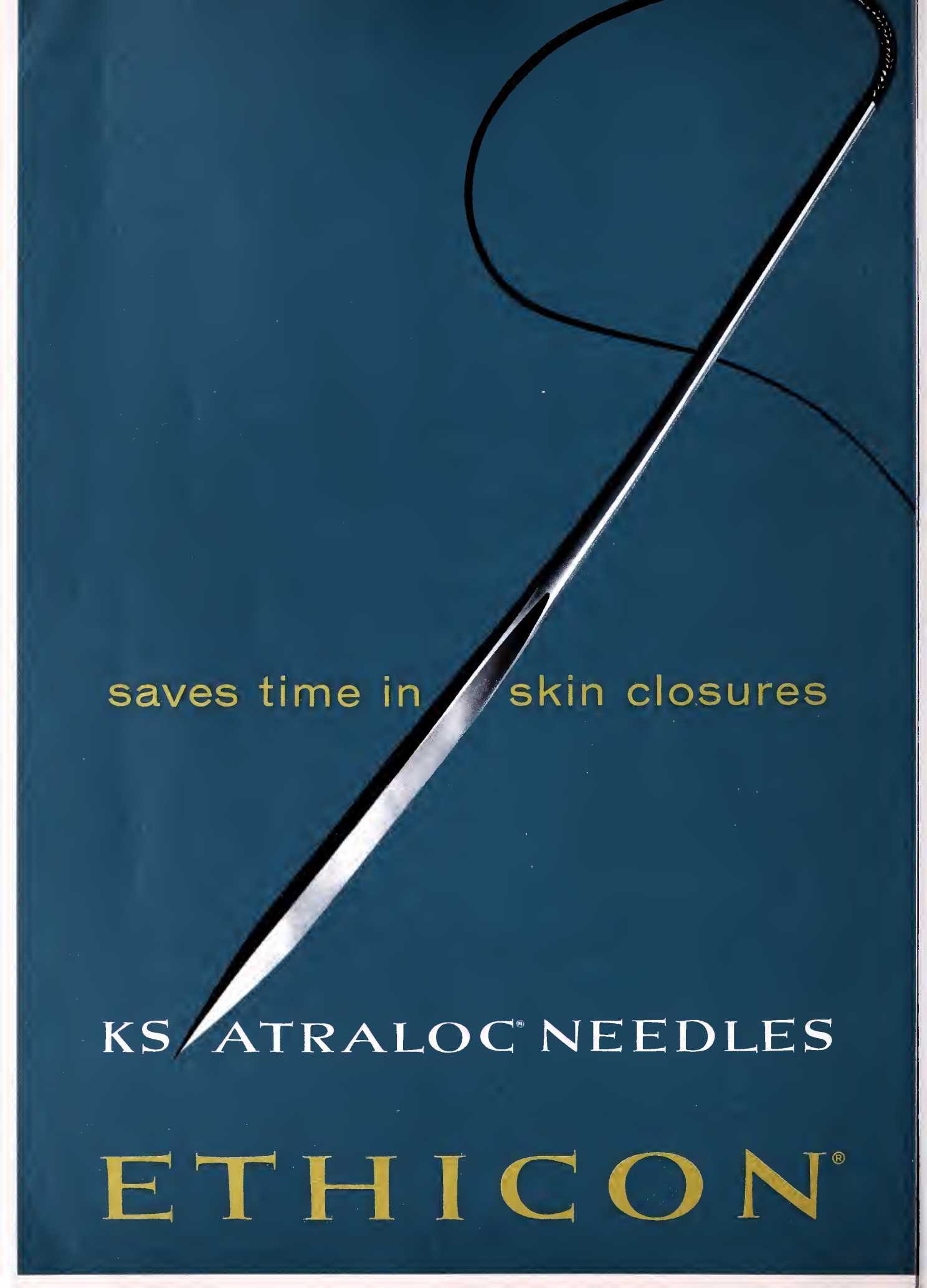
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References: 1. Bernstine, J. B., and Rokoff, A. E.: Vaginal Infections, Infestations and Discharges, New York, The Blakiston Company, Inc., 1953, p. 235. 2. Overstreet, E. W.: Arizona M. 10:383, 1953. 3. Schwartz, J.: Obst. Gyn., N. Y. 7:312, 1956. 4. Crossen, R. J.: Diseases of Women, St. Louis, The C. V. Mosby Company, 1953, p. 292.

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IN MEMORIAM

(*Continued from page 583*)

Leaving the Kalihi Receiving Station in 1897, Dr. Wayson entered private practice but up to 1910 he continued to serve the government on a part time basis. In 1910 he was made medical superintendent of the Kalihi Hospital and remained in that position until 1915. He was also a member of the Territorial Board of Health from 1905 to 1909, and from 1911 to 1918 he was the city-county physician for Honolulu. Resigning as city-county physician, Dr. Wayson took the position of sanitary expert, general health officer, and assistant administrator for the Territorial Board of Health.

Dr. Wayson specialized in the study of leprosy. In 1931 when the Board of Hospitals and Settlement was organized for the care of leprosy patients, a goal towards which Dr. Wayson had worked for many years, he was appointed the Board's Physician, a position he held until his retirement.

During his 50 years of practice, he also served as consulting dermatologist on the staffs of the hospitals on Oahu.

Dr. Wayson died on January 11, 1945, at the age of 75.

He was a Fellow of the American Medical Association, a Fellow of the American Academy of Dermatology and Syphilology, a member of the Society for Investigative Dermatology, a Fellow of the Royal Society of Tropical Diseases and Hygiene, a member of the Territorial Medical Association (president in 1906), a member of the Honolulu Medical Society, and a member of the Baltimore City Medical Society. Dr. Wayson also belonged to the Elks, Masons, and Odd Fellows. He was a charter member, and first president, of the Hawaii Dermatological Association.

Henry C. Sloggett

Henry C. Sloggett was an Englishman by birth.

His M.D. degree was received in London in 1878.

He first came to the Islands in the 70's with the British scientific exploring steamship, "Challenger."

About 1895 Dr. Sloggett returned to Honolulu from the state of Washington to practice with Dr. McLennan. He soon went into practice by himself, specializing in diseases of the eye and ear.

A few years later President Dole appointed Dr. Sloggett a member of the Board of Health. On the resignation of Dr. Cooper as president of the board, Dr. Sloggett succeeded him. During his presidency there was a recurrence of bubonic plague, which was successfully handled by the Board of Health without any general quarantine of business or commerce, although there were more cases to deal with in the year than were recorded in the epidemic of 1899-1900.

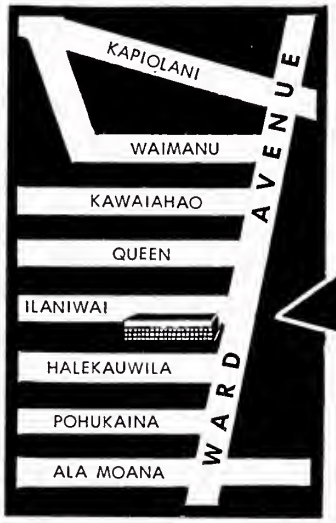
About 1901 Dr. Sloggett lost his wife and shortly thereafter resigned from the Board of Health and went to Shanghai in the service of the Oriental Insurance Company.

For the two years prior to his death, Dr. Sloggett was superintendent of the Insane Asylum. During his administration, the grounds were remodeled and new buildings were erected.

On March 24, 1905, Dr. Sloggett died in Honolulu. He was survived by his son, Digby, and a daughter, Mrs. J. F. Humburg.

Dr. Sloggett was a Mason and a member of the Hawaii Territorial Medical Society, serving as president in 1903.

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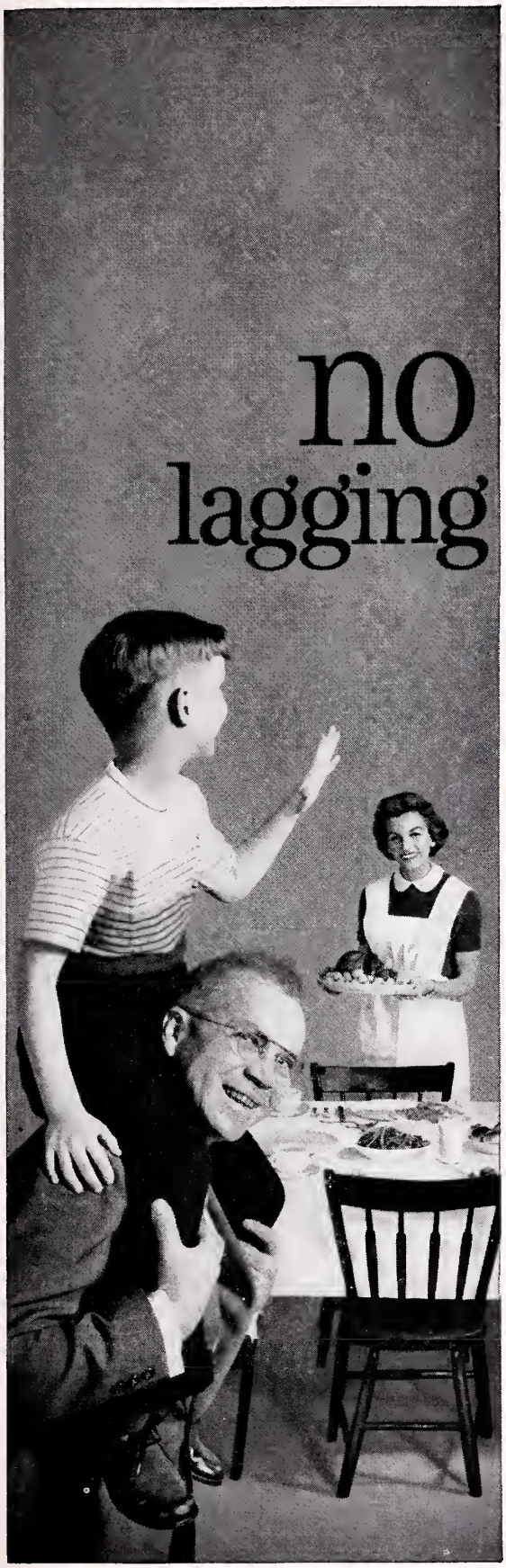
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BOOK REVIEWS

(*Continued from page 577*)

How to Overcome Colitis.

By Joseph F. Montague, M.D., 288 pp., Price $4.00, The Citadel Press, 1956.

"The burp, like the poor, will always be with us." So starts this humorously written medium for the masses. The provocative chapter titles are indicative of the overall wit; e.g. "Fables in 'Stomach Aches'," "Oh! My Aching Back," "Only a Pack a Day," "And a Little Wine for Thy Stomach's Sake."

Those reading for a "Do It Yourself" medium will be grossly disappointed. On the contrary, this book makes light of commercials. "Cure All" drugs are put in their proper place as specifics. Cathartics, as an end to all ends, are discredited individually or collectively. Food fad—relationships to disordered digestion is explored. Adherence to the Department of Health and Pure Food and Drug Act is maintained.

This is a seriously conceived and conscientiously ethical treatise lightly written for the "One in every home" afflicted with colitis.

The illustrations accompanying the text start with "Your Table of Contents," the food canal diagram, and end with "Rogues Gallery of Bad Colons," eight classical x-rays of pathological conditions.

This book is to be recommended to physicians for its practical approach to the patient's "gas" and "to those who are willing to be helped—as a step towards proper understanding—" "The facts of living."

RICHARD K. C. CHANG, M.D.

Wire Brush Surgery.

By James W. Burks, Jr., M.D., 154 pp., illus., Price $6.75, Charles C. Thomas, 1956.

The subject of dermabrasion or surgical planing of the skin is very thoroughly covered by the author, who bases his observations on over 1,000 clinical cases. Every detail of the procedure is discussed, including the applied basic sciences. The types of cases that do not respond to this procedure are also discussed as well as the type that give good reults. Complications and their treatment are also presented. The book is thoroughly illustrated with pictures and is a worthwhile addition to the library of anyone interested in this field.

LEABERT FERNANDEZ, M.D.

Clinical Laboratory Methods and Diagnosis—Volumes I and II.

By R. B. H. Gradwohl, M.D., 5th Ed., 2,452 pp., illus., Price $38.50, C. V. Mosby Company, 1956.

This is a two-volume edition covering most of the common clinical laboratory procedures. It suffers from lack of detail on some complicated and newer procedures but, in general, covers most of the problems in the clinical laboratory in detail. More than one test is presented in most cases. In those cases inadequately covered, references are present. For most procedures there are short physiological and clinical summaries. This is really unnecessary since the discussions are inadequate for the clinician and the laboratory portions are too detailed for him. Nevertheless, this is the most complete compilation of clinical laboratory tests in English, and is of value for every large clinical laboratory. The book is well bound, easily readable, and well illustrated.

W. HAROLD CIVIN, M.D.

Natural Childbirth.

By H. B. Atlee, M.D., 79 pp., illus., Price $2.75, Charles C. Thomas, 1956.

An interesting and informative book which deals well and sensibly with the psychological and emotional aids to conditioning the woman for delivery—aids so that she may overcome the discomforts, embarrassments, dissatisfactions, and fears of confinement. The book states the methods used and the information given to the patient starting early in the prenatal course.

I feel that this is a more orderly approach to an old subject and should be reviewed by all doctors practicing obstetrics as an aid to their armamentarium.

E. F. CUSHNIE, M.D.

Medical Effects of the Atomic Bomb in Japan.

Edited by Ashley W. Oughterson and Shields Warren, 477 pp., illus., Price $8.00, McGraw-Hill, 1956.

Drs. Oughterson and Warren have done an excellent job of condensing the six volume report of the Joint Commission for the Investigation of the Atomic Bomb in Japan. The authors have concisely and interestingly presented the horror and utter devastation caused by one of the smaller (20 K.T.) atomic bombs dropped on Hiroshima and Nagasaki on August 9, 1945. Every phase of the devastation has been covered, including extensive clinical material, hematology and pathology, using charts, pictures, diagrams, etc. The book enables one to gain important knowledge concerning the effects of ionizing radiation on the whole human being. Reading this book was time well spent.

LEABERT FERNANDEZ, M.D.

Postural Back Pain.

By Milton C. Cobey, M.D., 78 pp., illus., Price $3.00, Charles C. Thomas, 1956.

This monograph is in essence a short refresher course primarily concerned with postural back pain, with an occasional reminder of its organic causes.

The monograph because of its brevity cannot present the problem in its entirety; however, what it does present is interesting. It offers nothing new to the orthopedic surgeon; however, it would be of value to the pediatrician, gynecologist, and the general practitioner.

I. NADAMOTO, M.D.

Tumors of the Female Sex Organs. Part I. Hydatidiform Mole and Choriocarcinoma.

By Arthur T. Hertig, M.D., and Hazel Mansell, M.B., B.S., 63 pp., illus., Price $1.00, Armed Forces Institute of Pathology, 1956.

This fascicle deals with pathogenesis and classification in a thoroughly understandable manner and shows the difficulties and problems involved. Relationship to normal and abnormal pregnancy is stressed in the text and in pictures. The author's experience is tabulated and the illustrations are clear, both of the gross and of the microscopic, but the latter suffers, as do all photomicrographs on this subject which are not in color, by not being quite able to delineate the appearance to the newcomer in pathology. For pathologists and for obstetricians and gynecologists, the fascicle is a valuable supplementary reference, however.

W. HAROLD CIVIN, M.D.

The Physician-Writer's Book.

By Richard M. Hewitt, M.D., 415 pp., Price $9.00, W. B. Saunders Co., 1957.

The author's aim in this book was "to aid the inexperienced, inexpert, occasional physician-author . . . [writing] for other physicians. . . . The volume is not a style book [and] is not directed particularly to editors, although their friendly interest, if it may have that, will warm its papyraceous heart."

The aim is accurate. The inexperienced (or even the experienced!) medical author could not have a better reference work for his guidance and instruction. The disclaimer regarding editors is unduly modest; few medical editors are so skilled that they could not profit by scanning this information-packed volume. It seems almost certain to be widely used as a style book.

A few chapter headings indicate the book's scope: The Subject . . . The Title . . . Authorship . . . Ready Help . . . Cut It Down . . . Arrangement . . . Reports of Cases . . . and so on, are found in Part 1. Part 2 deals with the paragraph; Part 3, with the sentence; Part 4, with words; Part 5, with tables and illustrations; Part 6, with preparation of the manuscript; Part 7, with ethics. There are 70 pages of appendices on special subjects, and an excellent index.

Dr. Hewitt's long experience as Senior Consultant in the Section of Publications of the Mayo Clinic qualifies him almost uniquely for this special kind of guidance. Few editors have such close personal contact with their contributors, and few contributors have such help available to them. This book can make it available, and every physician writing for physicians would do well to use it.

HARRY L. ARNOLD, JR., M.D.

The Initial Management of Thoracic and Thoraco-Abdominal Trauma.

By Lawrence M. Shefts, M.D., 121 pp., illus., Price $6.50, Charles C. Thomas, 1956.

This is a very readable and informative monograph. The author's purpose, to present his experience in handling large numbers of thoracic and thoraco-abdominal injuries, is well fulfilled. He does this in a clear, concise, and interesting style. There are ample illustrations. His ideas on resuscitation and those on indications for surgery are particularly useful.

This book would be valuable to general and thoracic surgeons, physicians working in isolated areas, and doctors working in emergency room situations.

WILLIAM J. RICE, M.D.

Also Received

AMA Scientific Exhibits, 1956.

Price $10.00.

This book is composed of photographs of the various scientific exhibits of merit at the 1955 AMA convention at Atlantic City. The descriptive literature accompanying the exhibits is also included.

Aureomycin (Chlortetracycline).

By Mark H. Lepper, M.D., 156 pp., Price $4.00, Medical Encyclopedia, Inc., 1956.

Another Antibiotics Monograph (No. 7) on Aureomycin.

Services for Children With Hearing Impairment.

Prepared by the Committee on Child Health of the American Public Health Association, Price $1.50, American Public Health Association, Inc., 1956.

A pamphlet dealing with community services for children with hearing impairment.

Services for Children With Vision and Eye Problems.

Prepared jointly by the Committee on Child Health of the American Public Health Association and the National Society for the Prevention of Blindness, Price $1.50, American Public Health Association, Inc., 1956.

A pamphlet dealing with community services for children with vision and eye problems.

The Medical Clinics of North America.

Chicago Number, The Sick Heart, January 1957, W. B. Saunders Co.

A symposium from Chicago dealing with the various aspects of recent advances in heart diseases.

The Medical Clinics of North America.

Mayo Clinic Number, Hematologic Disorders, July, 1956, W. B. Saunders Co.

A symposium from Mayo Clinic on Hematologic Disorders.

The Surgical Clinics of North America.

Nationwide Number, Pediatric Surgery, December, 1956, W. B. Saunders Co.

A symposium dealing with pediatric surgery. Contains 1954-1956 index.

Classics in Arterial Hypertension.

By Arthur Ruskin, M.D., 358 pp., illustrated, Price $9.50, Charles C. Thomas, 1956.

A well documented and scholarly treatise on the historical background of arterial hypertension. This volume should be of interest to anyone interested in this important problem.

Mental Health Administration.

By Jack R. Ewalt, M.D., 168 pp., Price $5.50, Charles C. Thomas, 1956.

This little volume dealing with administrative problems of a hospital for psychiatric patients briefly discusses the various problems involved. It should be of interest to anyone having to do with the administration of such institutions.

Amino Acid Handbook.

By Richard J. Block, Ph.D., and Kathryn W. Weiss, A.B., 386 pp., Price $10.50, Charles C. Thomas, 1956.

This is a convenient reference book on the proteins and amino acids. It presents the most widely used methods of analysis as well as extensive tables and relevant data.

The Surgical Clinics of North America.

International Number—New Operations, August, 1956, W. B. Saunders Co.

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*Ferguson, J. T., and Linn, F. V. Z.: Antibiotic Med. & Clin. Therapy *3*:329, 1956.

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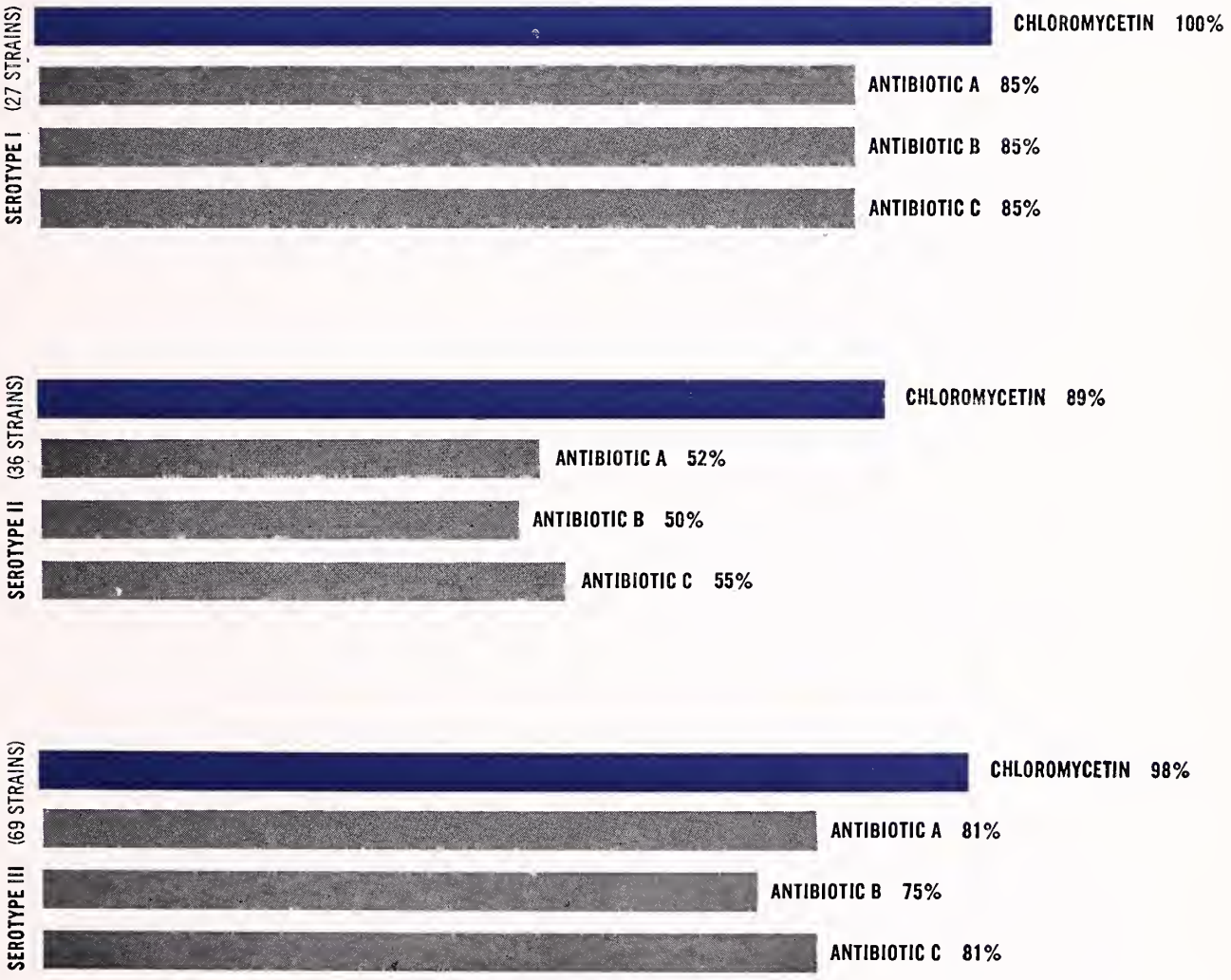
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Vitamin B_{12} activity concentrate	4 mcg.
Thiamine mononitrate	1.0 mg.
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Niacinamide	5 mg.
Pantothenic acid (Panthenol)	1.5 mg.
Pyridoxine hydrochloride	0.5 mg.

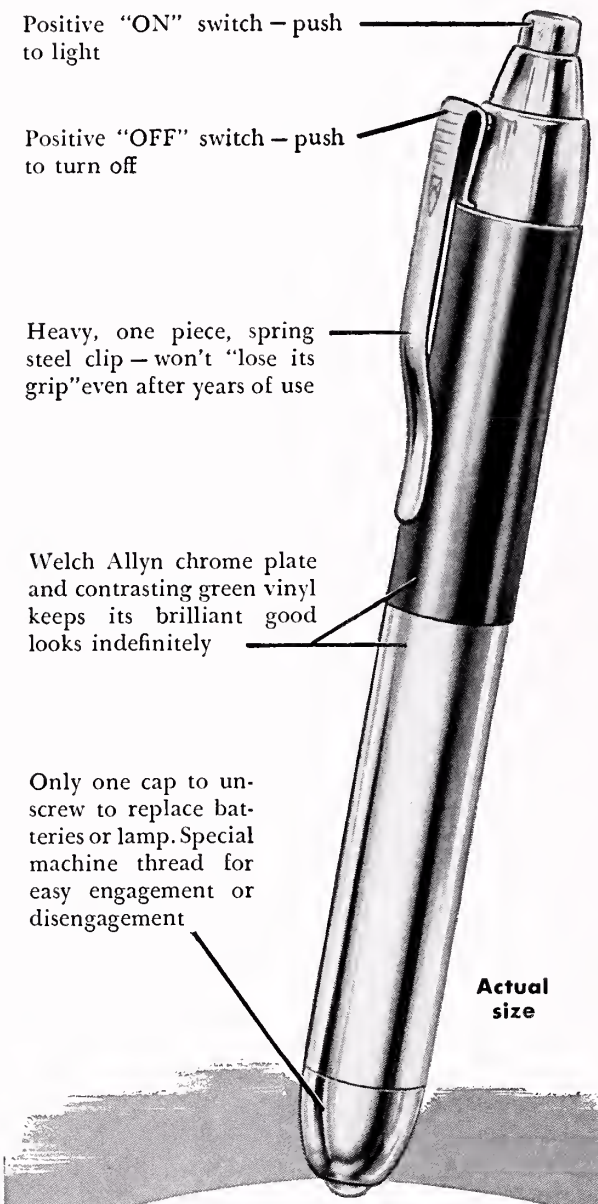
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l-Lysine	300 mg.	Pyridoxine (B_6)	5 mg.
Vitamin B_{12}	25 mcgm.	(INCREMIN Drops contain 1% alcohol)	
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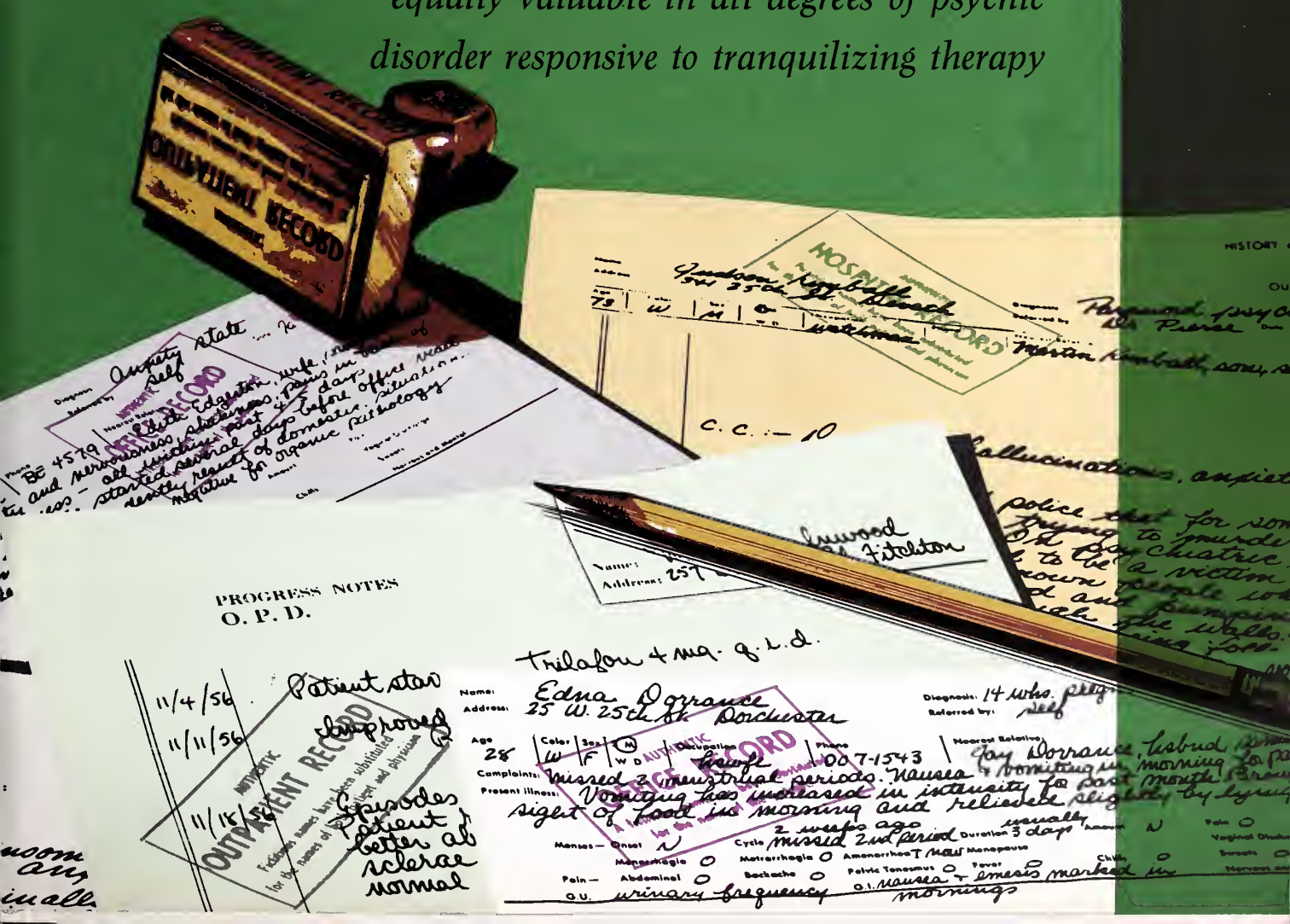
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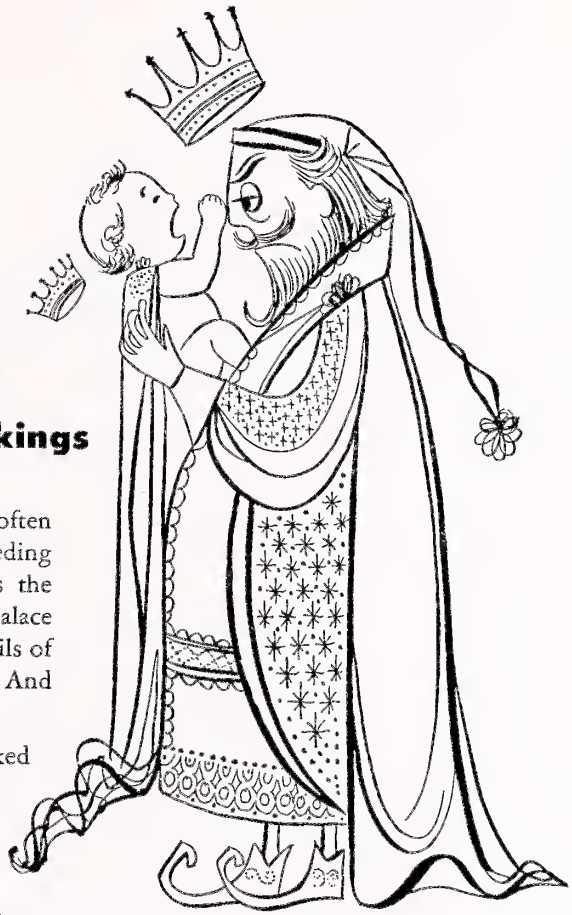
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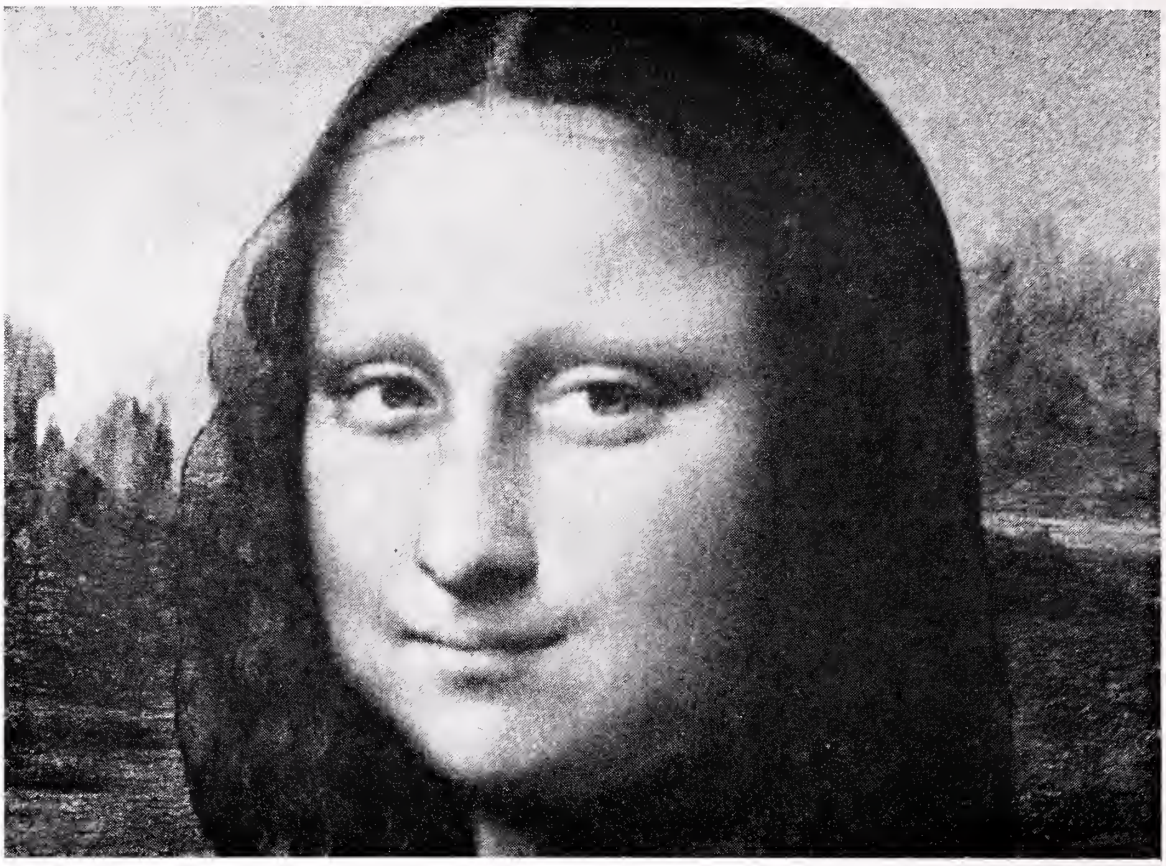
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Behne, D.; Clark, F.; Jennings, M.; Pallois, V.; Olson, H.; Wolf, L., ond Tyler, E. T.: West. J. Surg. 64:152, 1956.

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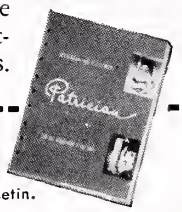
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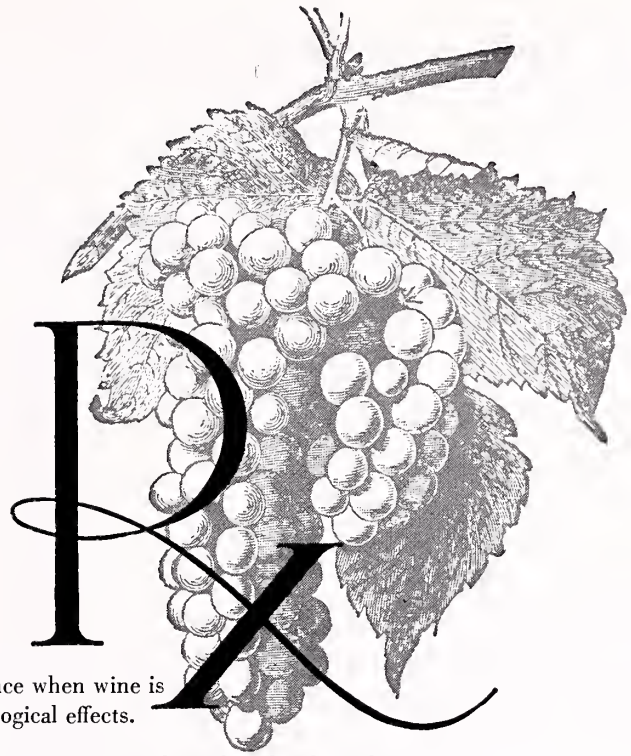
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(To Your Health)



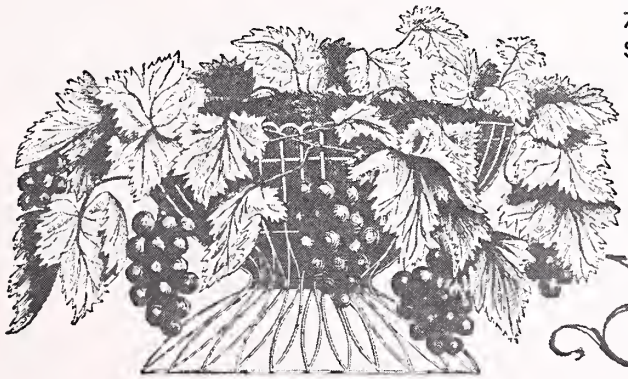
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Enzyme urine-sugar tests are sensitive and specific for glucose—excellent "yes" or "no" tests but undependable for quantitation. King and Hainline,[1] after testing 1,000 urines, found an enzymatic urine-sugar test unable to distinguish in the important range between ½ per cent and 2 per cent or more of urinary glucose. Leonards,[2] in a report on 4,020 tests, revealed that "...in 502 out of 804 tests the wrong interpretation was made." He concluded that enzymatic urine-sugar testing "...as a quantitative procedure is unsatisfactory and can lead to serious error in the interpretation of a patient's clinical condition."[2]

Failure to recognize this limitation of enzyme tests may result in incorrect insulin dosage,[2] and may lead to diabetic complications.

(1) King, J. W., and Hainline, A., Jr.: Commercial Glucose Oxidase Preparations for the Detection of Glucose in Urine, Cleveland Clin. Quart. **23**:212, 1956. (2) Leonards, J. R.: Evaluation of Enzyme Tests for Urinary Glucose, J.A.M.A. **163**:260 (Jan. 26) 1957.

reliable readings throughout the critical range—
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- well tolerated, relatively nontoxic
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WITHOUT IMPAIRING MENTAL OR PHYSICAL EFFICIENCY



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tranquilizer with muscle-relaxant action

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Supplied: 400 mg. scored tablets
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Usual dosage: One or two 400 mg. tablets t.i.d.

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Relaxes without impairing mental or physical efficiency

. . . well suited for prolonged therapy

1 "The primary finding of these studies is that meprobamate ['Miltown'] alone . . . produces no behavioral toxicity in our subjects as measured by our tests of driving, steadiness and vision."

Marquis, D. G., Kelly, E. L., Miller, J. G., Gerard, R. W. and Rapoport, A.: Ann. New York Acad. Sc. 67:701, May 9, 1957.

2 "Since it [meprobamate—'Miltown'] does not cloud consciousness or lessen intellectual capacity, it can be used . . . even by those busily occupied in intellectual work."

Keyes, B. L.: Pennsylvania M. J. 60:177, Feb. 1957.

3 ". . . the patient never describes himself as feeling detached or 'insulated' by the drug ['Miltown']. He remains completely in control of his faculties, both mental and physical . . ."

Sokoloff, O. J.: A.M.A. Arch. Dermat. & Syph. 74:393, Oct. 1956.

4 "It ['Miltown'] . . . does not cloud the sensorium, and has a helpful somnifacient effect devoid of 'hangover'."

Kessler, L. N. and Barnard, R. D.: M. Times 84:431, April 1956.

5 "In anxiety and tension states, meprobamate relaxes without dulling cortical function to the same extent as the commonly-used barbiturates."

Rindskopf, W., Ravreby, M., Gutenkauf, C. and Sands, S. L.: J. Iowa M. Soc. 47:57, Feb. 1957.

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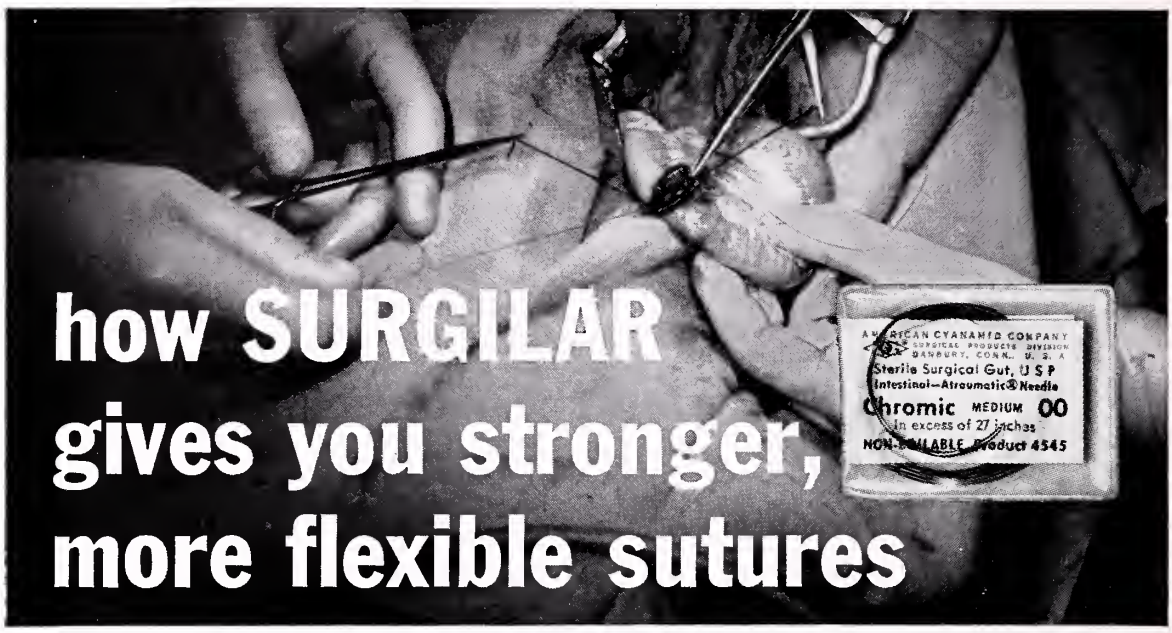


Formula:

Miltown® (meprobamate) 400 mg. (2-methyl-2-*n*-propyl-1,3-propanediol dicarbamate)
U. S. Patent 2,724,720

tridihexethyl iodide 25 mg. (3-diethylamino-1-cyclohexyl-1-phenyl-1-propanol-ethiodide)
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1. Alexander, Edythe L.: Mod Hosp., May, 1957.

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PRESIDENTIAL ADDRESS

WEBSTER BOYDEN, M.D.,* Lihue

MY REMARKS tonight will be brief and will consist of observations I made during the past year, including some opinions and a few suggestions.



I learned very soon that the job of being president was to be an educational experience. For the average physician this task is not an easy one; and to me, at least, the past year seems to have been filled with an unusual number of problems. Such problems would be less troublesome if we were better informed.

Thus if we analyze ourselves objectively, I believe most of us would discover that our thoughts and activities are rather circumscribed. We are too frequently tremendously concerned with ourselves and our work but quite oblivious to what is going on around us, and unaware of conditions which may be detrimental to our personal interest and those of the entire profession. The profession has been repeatedly urged to not only be more interested in medical affairs but to take part in all community activities.

To these admonitions I subscribe heartily, but tonight I wish to especially emphasize the importance of participating in our medical meetings. Of medical men and their meetings, Sir William Osler had this to say: "The daily round of a busy practitioner tends to develop an egoism of a most intense kind, to which there is no antidote. The few set-backs are forgotten, the mistakes are often buried, and ten years of successful work tend to make a man touchy, dogmatic, intolerant of correction, and abominably self-centered. To this mental attitude the medical society is the best corrective, and a man misses a good part of his education who does not get knocked about a bit by his colleagues in discussions and criticisms."

The attendance at the neighbor island society meetings is fairly good but that of the Honolulu County Society falls far short of what it should be. For the neighbor island societies, I suggest that they keep abreast of things medical that are taking place at the Territorial level.

Presidential Address given at the 101st Annual Meeting of the Hawaii Medical Association in Lihue, Kauai, May 3, 1957.
* President of the Hawaii Medical Association 1956-57.

Physicians need to combat their natural tendency to become self-centered, by taking more interest in their medical society and their community.

For the Honolulu County Society I strongly urge better attendance at their meetings. During the last year or so action on very important matters has been taken on several occasions when only about 10% of the membership was present. And it was these very matters that President Murray was referring to when he said last year in Seattle: "Today there is a greater need for a united, forceful, and informed profession than ever before. We have been caught in the throes of a social revolution which demanded something for nothing. Changes have been taking place all around us, and medicine has not escaped unscathed."

Whether the problem has to do with some government program, Blue Shield, a union or insurance plan, the important thing is that the members should take an intelligent interest in the subject and turn out in majority numbers to insure full discussion. These agencies are examples of the so-called "Third Party" in medicine, and they are with us to stay. The survival of the private physician now depends more and more on unity within the profession.

Important changes are taking place in the nation's economic structure, nearly all of which affect us and our profession. There are always individuals in every organization who are industrious, good speakers, and quite naturally tend to mold opinion in any group with which they associate. This has always been, sometimes for better, sometimes for worse. I suggest that all of us devote several hours of our reading each week to the study of our political economy. A well-informed membership will be a unified membership and will react for the benefit of both the patient and the doctor.

In closing I quote from Norman Vincent Peale, D.D.: "The physician is surely one of the most beloved figures in America. When sickness comes, the arrival of the doctor brings hope and comfort. To him, people look for healing and deliverance from pain and fear. 'Everything is all right; the doctor is here' is said with relief and love. What a privilege to enter with such affection into the lives of human beings."

Let us strive to so conduct ourselves as to be worthy of this privilege. Thank you.

MATERNAL MORTALITY IN HAWAII 1950-1955

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A COMMITTEE appointed by the President of the Hawaii Medical Association, with representatives of the Bureau of Maternal and Child Health as ex officio members, has met for a number of years to study maternal and neonatal deaths and to act in an advisory capacity for purposes of reducing these deaths and furnishing improved obstetrical care in our community. The rather bulky committee was recently divided into two sections, with general practitioners serving with the obstetricians for maternal death studies, and with pediatricians to study neonatal deaths. It is felt that this will increase the value of the studies, which can be made in considerable detail in sub-committee meetings, and subsequently presented to the entire group. Seminar type meetings are also held by this committee from time to time on the islands of Kauai, Maui, and Hawaii in conjunction with their county medical society meetings.



DR. BOWLES

These sessions are educational, and in addition to reviewing specific maternal and neonatal deaths anonymously, use the material obtained in informal round table discussions. When we analyze each death critically, it becomes repeatedly evident that we can cut our mortality still lower. These meetings should in due course help to approach this goal.

The most recent studies of maternal mortality in Hawaii, reported by Boog in 1949,[1] were obtained from an analysis of obstetrical deaths occurring during the years 1941-1945. At that time only 90 per cent of the mothers were hospitalized for delivery, whereas at the present time (1956) over 98 per cent of the women in the Territory have their babies in hospitals. Hawaii was shown to rank favorably in overall maternal mortality for the United States, being in twenty-first place,[2] together with Nevada, Massachusetts, Ohio, and Indiana; whereas from 1952-53 Hawaii ranked eleventh.

Operative deliveries, abortions, and lack of prenatal care are major factors in Hawaii's maternal death rate of 2.5 per 10,000 live births. The U.S. national rate is 6.0.

1950-1955 Studies

There were 73 maternal deaths during this period. The uncorrected maternal death rate for this series was 7.9 per 10,000 live births, or approximately 0.08 per cent, or 1 in 1,271 live births, including all deaths of women during pregnancy and for two months after delivery.

For some fairly up-to-date comparative figures, the following may be of interest:

		MATERNAL DEATH RATE
Territory of Hawaii	1941-45	0.070%
Territory of Hawaii	1950-55	0.079%
City of Los Angeles[2]	1945-50	1.23%
City of Los Angeles	1950	0.90%
State of Michigan[3]	1950-52	0.52%

Internationally, the following figures, obtained from the 1954 Demographic Year Book,[3] are also worth noting (Table 1).

TABLE 1.

Maternal Death Rate Per 10,000 Live Births.

	1952	1953
United States	6.7	6.0
Hawaii	7.7	2.5
Iowa	3.4	4.0
Minnesota	3.6	3.6
New Zealand	6.4	**
Australia	9.4	**
Sweden	8.6 (1951*)	**

* Only figure available.
** Not available.

The foregoing figures would seem to indicate that we have reached a point of no further progress in reducing maternal mortality in Hawaii. In fairness, however, one must call attention to two basic facts which alter statistics profoundly: (1) in 1955 only 16,305 babies were born in the entire Territory of Hawaii; and (2) in the last few years, intensive search of all death certificates has brought to light cases of maternal mortality that

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[1] Boog, J. M.: Maternal Mortality in Hawaii, HAWAII MED. J. 8:267 (Mar.-Apr.) 1949.

[2] Maternal Mortality Each State and Territory 1953, Vital Statistics Special Report. U.S.P.H.S.

[3] 1954 Demographic Year Book, Published Statistical Office of United Nations, Dept. of Economics and Social Affairs, New York, N. Y.

undoubtedly would have escaped our attention in earlier years. Hence, one or two maternal deaths per year more or less will cause great changes in maternal mortality statistics when these are contrasted with those obtained in heavily populated areas. Furthermore, about half of the 73 maternal deaths occurring in Hawaii in 1950-55 were preventable.

Distribution of Maternal Deaths

Residence: Forty-four maternal deaths were "rural." Twenty-nine were "urban"; i.e., they received their prenatal care and were delivered in Honolulu (1950 census population 248,034) or Hilo (1950 census population 27,198). Rural patients delivered in urban areas and receiving their prenatal care in Honolulu or Hilo were reallocated back to the rural areas for statistical purposes.

Preventability: A breakdown of the 73 maternal deaths studied by the Mortality Study Committee arrived at the following conclusions:

32 deaths considered preventable.
19 deaths considered possibly or probably preventable.
9 deaths considered not preventable.
8 deaths considered non-maternal.
5 deaths were inadequately reported and no conclusions could be drawn.

Additionally, several cases were placed in the "possibly" or "probably preventable" category because of incomplete data.

Out of Wedlock: Thirteen (18 per cent) of the mothers who died were pregnant out of wedlock. Only 3,551, or 4.6 per cent, of the live births during the period under observation were reported as illegitimate. The "out of wedlock" maternal death rate for 1950-54 compared to the death rate in women pregnant in wedlock was: 6.4 maternal deaths in wedlock per 10,000 live births (0.064 per cent); while 33.7 maternal deaths per 10,000 live births (0.337 per cent) occurred to those mothers pregnant out of wedlock.

One might conclude that prenatal supervision provides protection for the pregnant girl or mother. While good prenatal care is available in most areas in Hawaii, it is obvious that many women in the "out of wedlock" group do not take advantage of it. Education has a tremendous task to fulfill for the girls, their parents, and their friends. The Salvation Army with its Booth Memorial Home for unwed mothers does much to give this group sympathetic and understanding environment with accompanying good prenatal and obstetrical care. The big problem seems to be in reaching more of these mothers earlier, although they may constitute a risk group for socioeconomic reasons. A 1952-53 study of infant births in Hawaii showed that both married and single women who are not under medical care until late in pregnancy are contributing higher rates in maternal, infant, and fetal deaths.

Number of Pregnancies and Age: Comparing the incidence of maternal deaths in a six-year period with the average risk of pregnancy in the same gravida and age groups reveals some interesting data. The percentages of average pregnancy risk are taken from a study of all live births in 1952-53 in Hawaii. Since part of our study covers this period, the comparison may be considered valid (Table 2).

TABLE 2.—*Study of All Live Births in 1952-53 in Hawaii, in Relation to Gravidity.*

GRAVIDA	NO. OF MATERNAL DEATHS	% OF MAT. DEATHS IN 6 YRS.	% OF LIVE BORN BABIES TO WOMEN OF SAME GRAVIDA
1	24	32.9	30.5
2	11	15.1	26.1
3	10	13.7	18.3
4	5	6.8	11.1
5	3	4.1	6.1
6	3	4.1	3.2
7	5.6	5.5	1.8
8	2	2.7	1.08
9	3	4.1	.7
10	8	11.0	1.12

Granted that these figures are very small and a single digit will alter the percentage rates, they are nonetheless showing significant points. Gravida I and VI, and over, contribute to higher percentages of maternal deaths. There is little appreciable increase in risk in Gravida II through V. Likewise mothers in the youngest and older age groups contribute a higher portion to the maternal deaths than to the live births (table 3).

The importance of early consistent supervision of the younger women may at times be overlooked because of their casual acceptance of minor discomforts as something to be expected in pregnancy. They are also prone to overdo and not be too careful of diet. Again a high portion of them fall in the unwed group whose high risk has been pointed out. With the older mother and the grand multipara, we are faced with the risks of chronic diseases and weight gain plus indifference to early medical care and the socioeconomic difficulties that are inherent in many large families.

In the interest of giving high risk groups the maximum chance for safe delivery and recovery, women with complications, unwed mothers, very young primipara, and grand multipara could be referred to Public Health Nurses for home supervision. The nurses visiting in the homes can help reduce tensions and worries and reinforce the physician's advice and facilitate carrying out his recommendations; they can frequently help improve undesirable housing and sanitation, and promote faithful reporting for medical supervision. Since

nurses are available on all the islands and in every district, it seems their value to the maternity patient is not well understood, as only 4 of the 73 maternal deaths studied were cases known to Public Health Nurses.

TABLE 3.—*Study of All Live Births in 1952-53 in Hawaii, in Relation to Age of Mother.*

AGE GROUP	NO. OF MATERNAL DEATHS	% OF 1950-55 DEATHS	% OF LIVE BORN INFANTS TO SAME AGE GROUP (1952-53)
15-19 years	9	12.3	8
20-24 years	13	17.8	32.6
25-29 years	19	26.0	32.4
30-34 years	11	15.1	18.7
35-39 years	13	17.8	6.9
40-44 years	8	11.0	1.3

Samoan and Korean groups contributed 1 death each. Worthy of comment is the fact that Portuguese were statistically included in the Caucasian birth count and therefore figured in the Caucasian maternal death rate. Portuguese accounted for 5 or 41.6 per cent out of the 12 Caucasian deaths. This is significant, since the total per cent of Portuguese in the overall Caucasian population is much lower than 41 per cent. True figures are not available (table 4).

TABLE 4.—*Maternal Death Rate by Ethnic Groups in Hawaii (1950-54)*

	MATERNAL DEATH RATE PER 10,000 LIVE BIRTHS
All groups	7.7
Hawaiian or part-Hawaiian	9.4
Filipino	8.45
Caucasian	7.2
Chinese	6.8
Japanese	6.35

Mode of delivery in 65 (of the 73) maternal deaths:

	NUMBER	PER CENT OF ALL MATERNAL CAUSES
Operative deliveries	13	20.0
(a) cesarean section	9	13.8
(b) "high forceps" or "manual versions"	4	6.1
Breech presentation	7	10.8
Postmortem cesarean sections	8	12.3
Undelivered at time of death	9	13.8
Time of death in relation to duration of pregnancy:		
Before 5th month of pregnancy	13	20.0
In 5th month of pregnancy	3	4.6
In 6th month of pregnancy	3	4.6
In 7th and 8th months of pregnancy	7	10.8
In 9th and 10th months of pregnancy	33	50.8
Over 42 weeks gestation	3	4.6
1-2 months post-delivery	3	4.6
Maternal deaths by causes:		
Maternal deaths from obstetrical causes	65	
Maternal deaths from non-obstetrical causes	8	
Total maternal deaths, all causes	73	

The high incidence of abortion deaths, 4 of which occurred in married women, points up the importance of more and better education of the public in regard to the dangers involved. The families repeatedly state that they have heard the introduction of air into the uterus is a safe way to abort. Obviously the insidious word-of-mouth publicity of the aborters is reaching people in a way our health education is not. Majoska[4] has recently reported a series of air embolism fatalities in criminal abortions. A special detail is assigned to seek out and prosecute abortionists but many women attempt the act themselves. It would seem wise for physicians and office, hospital and Public Health Nurses to make use of every opportunity to emphasize the dangers of attempting abortion (table 5, graph 1).

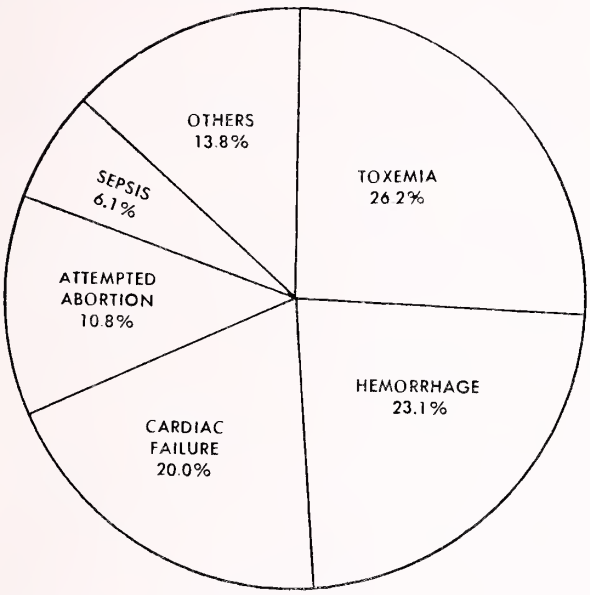
The high rate also brings to mind the problem of mental and emotional illness during pregnancy. One wonders if adequate reports were available, whether the number of suicides or attempted suicides in women in the childbearing ages would not further indicate a need for special emphasis on mental health in pregnancy. In 1954 suicide ranked as the ninth leading cause of death in Hawaii. Present laws do not mandate autopsies on all suicides and the number of pregnancies involved is therefore not known.

TABLE 5.—*Maternal Deaths by Leading Causes (1950-55).*

Toxemias:		
Toxemia	5	
Toxemia with eclampsia	7	
Nephritis with diabetes	1	
Nephritis with uremia of pregnancy	2	
Nephritis with lower nephron nephrosis	2	
TOTAL	17	26.2%
Hemorrhage:		
Postpartum (1 uterine atony) (1 cervical tear)	6	
Premature separation of placenta	3	
Placenta previa	1	
Post-cesarean hemorrhage	1	
Ectopic pregnancy	3	
Ruptured uterus	1	
TOTAL	15	23.1%
Cardiac Failure:		
Cardiac failure	4	
Cardiac failure with hypertension	4	
Cardiac failure, congestive heart disease	3	
Rheumatic carditis	2	
TOTAL	13	20.0%
Attempted Abortion:		
Pulmonary embolism	6	
Sepsis	1	
TOTAL	7	10.8%
Sepsis	4	6.1%
Other	9	13.8%

[4] Majoska, A. V.: Air Embolism Fatalities in Criminal Abortions, HAWAII MED. J. 15:451 (May-June) 1956.

GRAPH 1.—Maternal Deaths by Cause in Hawaii (1950-55).



Discussion and Recommendations

Now at long last we get to the kernel of the nut, viz.: what to do about it and how to reduce maternal (and fetal) mortality still further. A recent article by Ott and Longyear[5] is so much to the point in its every detail that it seems fitting to use suggestions made therein and by the discussants as a baseline from which to proceed in improving the function of the committee and in furthering its objectives; namely, fewer maternal and fetal deaths (if it were possible, none).

We support the recommendation that the terminology of Ott and Longyear be followed if confusion is to be cleared up regarding the classification of deaths related to pregnancy. They list three main categories: (1) obstetric causes; (2) non-obstetric causes; and (3) non-related causes (suicide, accidents, idiosyncrasies, malignancy, etc.).

[5] Ott, H. A. and Longyear, H. W.: Problems of Maternal Death Studies: Some Recommendations for Their Solution, Am. J. Obst. & Gynec. 71:1012 (May) 1956.

Ott and Longyear state that "Committee members contribute generously in time and effort and should not be expected to pay the costs of these studies from their pockets." To date, since the committee has made periodic visits to Kauai, Maui, and Hawaii, and representatives of those islands have come to Honolulu, committee members have paid their own expenses with some help from the local medical societies. This seems scarcely as it should be.

Among some recommendations of our own can be listed the following:

1. More nearly adequate reporting of requested study form data.
2. More autopsies.
3. Compulsory autopsies or thorough physical examinations in the case of suicide or attempted suicide.
4. More use of the panel of free consultants available through the Bureau of Maternal and Child Health, Department of Health, Territory of Hawaii.
5. More use of Public Health Nurses (in only 4 of the 73 maternal deaths had Public Health Nursing service been used). This would contribute greatly to
6. Regular check-ups including antepartum and postpartum visits.

In closing, it must be emphasized that as good as our apparent progress has been, we still have far to go and the committee should by all means continue to widen its scope.

Acknowledgement

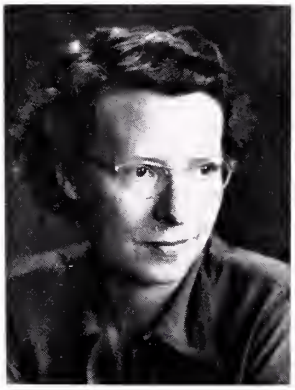
Miss Leona Rubbelke, R.N., and other personnel of the Hawaii Territorial Department of Health have been of great service in obtaining material for this paper and acknowledgement is hereby given them; also to the Maternal and Neonatal Study Committee and the Maternal Advisory Committee of the Hawaii Medical Association for their excellent work in improving obstetrical service in Hawaii.

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BIRTH WEIGHT PATTERNS BY RACE IN HAWAII

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THIS IS the first report in a detailed study of birth weights in relation to various factors as shown on birth and infant death certificates. In cooperation with the U. S. Children's Bureau, the study is being made by the Bureau of Health Statistics, both of the Territorial Department of Health.



DR. CONNOR

This report indicates the magnitude of the premature infant problem in Hawaii, weight distribution, and the influence of birth weight on infant mortality. A predominating feature is the differences among the various races in Hawaii. Other reports will discuss birth weight by race in connection with such factors as length of gestation, age of mother, parity, socioeconomic status, prenatal care, illegitimacy, etc.

The Territory affords an excellent field for studies of birth weight for these reasons: Birth certificates have carried the weight item since 1946; statistical tabulations involving birth weight are available over a series of years; more than 98 per cent of all births occur in hospitals where weighing is routine and likely to be accurate; and completeness of both birth and infant death registration is close to one hundred per cent. Furthermore, the Territory affords an unequalled opportunity to study peoples of various racial descent living together in the same setting and under comparable conditions.

Premature Criterion. For classification purposes, infants weighing 2,500 grams or less at birth are considered "premature." This weight criterion was recommended by the American Academy of Pediatrics in 1935; it was later adopted in the International Statistical Classification of Diseases, Injuries, and Causes of Death of 1948.

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The authors are staff members of the Territorial Department of Health; Dr. Angie Connor is chief of the Bureau of Maternal and Child Health and Crippled Children, Charles G. Bennett is chief of the Bureau of Health Statistics, and Lillian S. K. Louis is head of the Research and Analysis Section of the Bureau of Health Statistics.

Mortality of premature infants in Hawaii, though lower than in the U.S. as a whole, is 17 times that of mature infants; and, unlike the mortality rate of the latter, it is not declining.

It does not mean that every infant weighing 2,500 grams or less is in fact immature. Such factors as race, sex, and plurality may produce "mature" babies weighing less than the criterion. To some extent, this shortcoming may be offset by the fact that some other babies weighing more than 2,500 grams possess the less robust characteristics of the premature. Though not exact, the criterion is a useful one, particularly for the presentation of statistics.

Race Classification. Over a period of years, the Bureau of Health Statistics has used a set of arbitrary rules to determine race of child on birth and death certificates for statistical coding purposes when the parents are specified as of different or mixed racial descent or where the race of one parent is not stated. Although this procedure does not produce exact results, its use appears practical and desirable while a race breakdown is retained for natality and mortality statistics.

These rules for determining race of child are as follows:

1) If either parent is Hawaiian or part Hawaiian, code as part Hawaiian.
2) If one parent is Caucasian and the other parent non-white, code the race of the non-white parent.
3) If one parent is Negro, or a mixture of Negro with any other race but Hawaiian or part Hawaiian, code should be that of Negro.
4) If parents are members of different non-white races, other than Hawaiian, part Hawaiian, or Negro, code according to race of father. If the father is of mixed non-white racial extraction, use the race indicated by surname.
5) If race of either parent is not given, code race of child as that of the other parent.

Table 1 gives the civilian population of Hawaii based on the 1950 federal census reports by the race classification frequently used in the Bureau.

As a preliminary step in birth weight studies, tabulations were made to test the validity of the Bureau's race classification scheme. Approximately

TABLE 1.—*Civilian Population by Race, Territory of Hawaii, 1950.*[a]

RACE	NUMBER	PERCENT
All races	476,913[b]	100.0
Hawaiian	12,108	2.5
Part-Hawaiian	73,483	15.4
Puerto Rican	8,852	1.9
Caucasian	95,331	20.0
Chinese	32,225	6.8
Japanese	184,119	38.6
Korean	6,492	1.4
Filipino	60,453	12.6
Other races	3,850	0.8

[a] Based on 1950 decennial census reports.
[b] As of January 1, 1956, the total civilian population of the Territory was estimated to be 516,878.

TABLE 2.—*Single Births by Race of Child as Indicated by Race of Parents Shown on Birth Certificates, 1952-1953.*

RACE CLASSIFICATION OF CHILD	TOTAL BIRTHS[a]	FATHER AND MOTHER SPECIFIED AS OF SAME RACE	PARENTS OF DIFFERENT OR MIXED RACE OR RACE OF ONE PARENT NOT STATED[b]	
			NUMBER	PERCENT[c]
All races	30,877	19,374	11,503	37
Hawaiian	302	212	90	29
Part-Hawaiian	7,766		7,766	100
Puerto Rican	687	256	431	63
Caucasian	7,063	6,898	165	2
Chinese	1,762	1,221	541	31
Japanese	9,517	8,482	1,035	11
Korean	436	139	297	68
Filipino	3,344	2,166	1,178	35

[a] Excluding 300 births in the classification "all other races."
[b] Arbitrary rules applied to determine race of child.
[c] Percent of total births in each race classification.

31,000 birth certificates for children born during 1952 and 1953 were used.

Thirty-seven per cent of the certificates showed parents of different or mixed racial descent or the race of one parent not stated; conversely, 63 per cent of the certificates indicated both parents of identical races (Table 2).

More than two-thirds of those showing parents not of identical races were in the part Hawaiian group concerning which there is little question of classification accuracy (see rule 1 above). Disregarding this group, then only 12 per cent of all certificates studied showed parents not of identical races. In other words, Bureau rules for determining race of child were most open to question in twelve cases out of a hundred.

Among the relatively large Japanese and Caucasian groups, the possibility of invalid classification was small. About 98 per cent of the certificates for Caucasians and 89 per cent of those for Japanese specified parents as of the same race.

The races (except part Hawaiian) most likely to have certificates showing mixed parentage or race of one parent omitted were Chinese, Korean, Puerto Rican, Filipino, and Hawaiian. Therefore, it was among these races that Bureau rules were most likely to place children in other than the most appropriate racial category.

However, evidence indicates that had all certificates in each racial category specified the parents as of the same race, the results of birth weight tabulations would have shown little difference.

For example, when the average and median weights by sex and race of all infants classified racially by Bureau rules are compared with similar data for infants having parents specified as of the same race, no statistically significant differences appear (Table 3). For males, differences ranged from 3 grams for Korean to 55 grams for Hawaiian; for females, the differences were from only one gram for Chinese to 43 grams for Hawaiian.

A similar comparison of the percentage of children weighing 2,500 grams or less at birth by race likewise showed no significant difference for any race. In other words, the proportion premature by weight using certificates for all children was about the same as using only certificates where races of parents were identical.

On the basis of these findings, the analysis of birth weight data proceeded with considerable confidence that racial differences would be about the same employing the usual race classification scheme of the Bureau as would be the case using only birth certificates showing both parents of identical races.

TABLE 3.—*Median Weights of Single Births in Two Categories*[a] *by Race and Sex, 1952-1953.*

RACE CLASSIFICATION OF CHILD	MEDIAN WEIGHTS IN GRAMS					
	MALES			FEMALES		
	ALL BIRTHS	PARENTS OF SAME RACE	DIFFERENCE	ALL BIRTHS	PARENTS OF SAME RACE	DIFFERENCE
Hawaiian	3,272	3,327	55	3,200	3,243	43
Part-Hawaiian	3,305			3,290		
Puerto Rican	3,239	3,197	42	3,122	3,107	15
Caucasian	3,364	3,368	4	3,246	3,248	2
Chinese	3,238	3,222	16	3,147	3,146	1
Japanese	3,220	3,214	6	3,149	3,141	8
Korean	3,276	3,273	3	3,175	3,188	13
Filipino	3,117	3,102	15	3,044	3,025	19

[a] Category 1: Total births including both racially mixed parentage and parents of the same race. In racially mixed cases, the race of child was determined by arbitrary rules.
Category 2: Limited to births where the parents were of the same race.

TABLE 4.—*Premature Births and Deaths of Premature Infants by Years, 1950-1954.*[a]

YEAR	PREMATURE BIRTHS		DEATHS OF PREMATURE INFANTS UNDER ONE YEAR OF AGE		
	NUMBER	PERCENT OF ALL BIRTHS	NUMBER	RATE[b]	PERCENT OF ALL INFANT DEATHS
1950	1,111	7.9	163	146.7	51.3
1951	1,159	8.0	191	164.7	59.0
1952	1,232	7.9	171	138.8	54.1
1953	1,270	7.8	190	149.6	59.4
1954	1,313	8.1	219	166.7	62.2

[a] From annual reports of the Territorial Department of Health. Includes both single and multiple births.
[b] Number of infant deaths per 1,000 premature births.

Magnitude of the Premature Problem

In the five year period, 1950-1954, the percentage of premature infants according to weight in Hawaii varied from 7.8 to 8.1 with no appreciable trend discernible either upward or downward (Table 4). The number of prematures increased from 1,111 in 1950 to 1,313 in 1954, but there was a comparable increase in the total number of births.

Apparently, efforts to reduce premature births have not increased in effectiveness during recent years, emphasizing the need for research on the causes and prevention of prematurity.

During the five-year period, the infant mortality rate among prematures (Table 4) averaged nearly seven times greater than the death rate for all infants under one year. No trend downward in this premature death rate was evident; at the same time, the general infant mortality rate was gradually falling (Annual Reports of the Territorial Department of Health).

Furthermore, the proportion of prematures among infant deaths during the period appears to be on the increase. This proportion varied from 51.3 per cent (163 infants) in 1950 to 62.2 (219 infants) in 1954 (Table 4).

These statistics tend to indicate that measures to save infant lives are less effective for prematures than for the heavier weight babies. It is also in line with the assertion of Dr. H. E. Bowles that "despite the astonishing reduction in maternal mortality in this community in recent years, deaths of the immature fetus in utero and of the immature infant after birth remain deplorably high by comparison with maternal deaths."[1]

According to data tabulated in the National Office of Vital Statistics, 8.2 per cent of all births in Hawaii during 1950 and 1951 combined, and 7.4 per cent in the United States as a whole during January and February, 1950, were premature (weighed 2,500 grams or less). Other comparative data tabulated by the National Office corroborate this slight difference in percentages.

It appears from these data that the premature problem percentagewise is somewhat greater in Hawaii than in the nation as a whole. However, due to the large proportion of oriental people in Hawaii comparatively small in stature, it may be that a higher proportion of babies weighing 2,500 grams or less are more mature than is the case countrywide. If so, the actual premature problem may be no greater here, or even less, than in the nation.

Of the 21 registration areas included in the national office study, 13 had percentages lower and 7 higher than Hawaii. The highest premature percentage was for New Mexico (10.6 per cent) and the lowest for Minnesota (5.8 per cent).

Broken down by single and plural births and by Caucasian and non-Caucasian, the data show a greater difference between Hawaii and the nation (Table 5). In the case of single births, 1.1 per cent more in Hawaii were premature, while for plural births the picture was reversed—2.4 per cent more in the nation were premature.

TABLE 5.—*Percentage of Births Premature in the Territory of Hawaii and the United States by Plurality and Race.*[a]

PLURALITY AND RACE	TERRITORY OF HAWAII[b]	UNITED STATES[c]
All births	8.2	7.4
Single births	7.5	6.4
Caucasian	7.2	6.0
Non-Caucasian	7.5	8.6
Plural births	51.6	53.0
Caucasian	54.3	52.8
Non-Caucasian	50.5	54.0

[a] From *Vital Statistics—Special Reports*, volume 38, No. 18, National Office of Vital Statistics, 1955.
[b] Based on births during 1950 and 1951.
[c] Based on births during January-March 1950.

This reversal for plural births was due to non-Caucasian infants of which only 50.5 per cent in Hawaii (compared with 54 per cent of non-Caucasians in the nation) were premature at birth. Non-Caucasian single births were also less likely to be premature in Hawaii, but to a lesser extent than plural.

Both single and plural Caucasian infants were more likely to be premature in Hawaii, but in each

[1] Bowles, H. E.: Premature Intra-uterine and Neonatal Deaths, Proc. Staff Meet. The Clinic 17: (July) 1951.

case the proportion of premature Caucasians in the nation was less than two per cent lower than in Hawaii.

In the country as a whole, Negroes make up the greatest bulk of non-Caucasians, while in Hawaii it is people of oriental descent with Japanese predominating.

We can only conjecture why the non-Caucasian group in Hawaii should have significantly fewer births of premature weight. Similarly, why should Caucasians in Hawaii tend to have somewhat more prematures than in the country as a whole? This may involve such factors as economic circumstances, availability of medical care, average age of mother, anatomical structure, habits, and psychological considerations.

The neonatal death rate per 1,000 prematures was 146.7 in Hawaii, compared to 173.7 in the nation (Table 6). In contrast, similar rates among births of more than 2,500 grams were only 5.7 and 7.8 respectively.

TABLE 6.—*Neonatal Death Rates[a] of Premature and Non-Premature Infants in the Territory of Hawaii and the United States by Race.[b]*

RACE	PREMATURE		NOT PREMATURE	
	HAWAII[c]	UNITED STATES[d]	HAWAII[c]	UNITED STATES[d]
All neonatal deaths..	146.7	173.7	5.7	7.8
Caucasian	171.7	175.8	5.8	7.1
Non-Caucasian	140.4	164.7	5.7	11.9

[a] Deaths under 28 days per 1,000 live births.
[b] From *Vital Statistics—Special Reports*, volume 38, No. 18, National Office of Vital Statistics, 1955.
[c] Based on births during 1950 and 1951.
[d] Based on births during January-March 1950.

Of 21 registration areas included in the study, only one, New York City, had a lower neonatal rate among prematures than Hawaii; similarly, only one area, Connecticut, had a lower neonatal rate among non-premature births.

This is in line with general infant mortality rates; i.e., deaths under one year per 1,000 births. According to tabulations of the National Office of Vital Statistics for 1953,[2] Hawaii had the lowest infant mortality rate in the entire nation.

By race, Caucasians had a neonatal death rate among prematures only slightly lower than in the nation. On the other hand, non-Caucasians not only had a premature death rate lower than non-Caucasians in the country as a whole (140.4 compared to 164.7), but also much lower than Caucasians in either the nation or Hawaii.

Among infants heavier than prematures, both Caucasian and non-Caucasian death rates were also lower in Hawaii with differences more pronounced than among prematures. The death rate among non-Caucasians in Hawaii was less than half that among non-Caucasians in the country as a whole (5.7 compared to 11.9).

It appears then from the national office tabulations that prematures according to weight in Hawaii are less likely to die within the neonatal period than similar prematures in the country as a whole and that this is due in major part to the survival of non-Caucasians beyond the neonatal period.

There is speculation that some non-Caucasians in Hawaii normally have lighter weight babies than Caucasian or non-Caucasians on the mainland and that this may be an important factor in producing the lower neonatal rates; i.e., many of the Hawaiian non-Caucasian infants classified as premature by weight are in reality more mature than Caucasian and mainland non-Caucasian infants of the same weight and therefore have better chances of survival. Further investigation would be necessary to verify this surmise.

Birth Weight Distribution

The median weight of singly born infants during the two-year period was 3,225 grams with Caucasians having the highest (3,305 grams) and Filipinos the lowest (3,083 grams) (Table 7).

[2] "Infant Mortality, 1953." Vital Statistics-Special Reports, National Summaries, volume 42, number 15. National Office of Vital Statistics, 1956.

TABLE 7.—*Percentage Distribution of Single Live Births by Birth Weight and Race, Territory of Hawaii, 1952-1953.*

WEIGHT IN GRAMS		ALL RACES	HAWAIIAN	PART-HAWAIIAN	PUERTO RICAN	CAUCASIAN	CHINESE	JAPANESE	KOREAN	FILIPINO
TOTAL	*Number*	31,123[a]	297	7,742	685	7,055	1,760	9,511	436	3,337
	Percent	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
1,000 or less		0.4	0.7	0.4	0.3	0.5	0.5	0.3		0.4
1,001–1,500		0.4	1.0	0.4	0.7	0.3	0.4	0.3	0.2	0.8
1,501–2,000		1.2	1.0	1.1	1.2	1.2	0.8	1.1	1.2	1.8
2,001–2,500		5.2	6.7	4.8	8.0	4.2	4.7	4.9	3.9	8.6
2,501–3,000		23.8	20.9	21.5	25.3	19.0	26.0	26.2	24.1	31.8
3,001–3,500		42.5	38.1	40.9	40.1	40.7	45.3	45.8	46.1	40.1
3,501–4,000		21.3	24.2	23.7	20.7	26.8	19.0	18.0	20.2	14.3
4,001–4,500		4.4	5.7	5.9	3.1	6.3	2.7	2.9	3.4	2.0
4,501 and over		0.8	1.7	1.3	0.6	1.0	0.6	0.5	0.9	0.2
Median Weight in Grams		3,225	3,259	3,267	3,182	3,305	3,195	3,187	3,225	3,083

[a] Includes 300 births in the category "all other races."

The other six races classified ranged in between with respect to median weight. Hawaiians, part Hawaiians, and Koreans were most alike in one group and Chinese, Japanese, and Puerto Ricans most alike as another group with the latter being somewhat lighter.

For each race, the modal weight class was 3,001-3,500 grams. Symmetry around this peak, however, varied considerably by race.

For Hawaiians, part Hawaiians and particularly Caucasians, the second highest concentration was in the higher weight class of 3,501-4,000 grams, while for Puerto Ricans, Chinese, Japanese, and especially Filipinos, the second highest concentration was in the lower weight class of 2,501-3,000 grams. In this beginning weight class of mature infants (2,501-3,000 grams), the percentage of births varied from 31.8 per cent for Filipinos to only 19 per cent for Caucasians.

Less than one per cent of all births weighed 4,501 grams and over. Hawaiians, part Hawaiians, Koreans, and Caucasians as a group had a higher proportion in this weight class than Chinese, Japanese, Puerto Ricans, and Filipinos.

The percentage premature (2,500 grams and less) ranged from 5.3 per cent for Koreans to 11.6 per cent for Filipinos. The average percentage for all races was 7.2 (Chart I). It is notable that the Filipino rate was 62 per cent higher than the average and the Korean rate 24 per cent lower.

As a group, Koreans, Caucasians, Chinese, part Hawaiians, and Japanese were markedly lower in the percentage premature than Hawaiians, Puerto Ricans, and Filipinos.

Of the prematures, about three-fourths were in the borderline class (2,001-2,500 grams) and only one-tenth in the class of 1,500 grams or less. By race, there was considerable variation of percentages in each weight class of the premature group. The proportion of Caucasian infants in the borderline class (2,001-2,500 grams) was noticeably smaller than for other races while the proportion of Filipinos was larger.

By sex, males of each race averaged heavier weights than females. For the entire group of births, the males averaged 88 grams heavier. Although this difference is not large, it is statistically significant. Differences between male and female weights were greatest for Caucasian and Korean babies and least for Hawaiian, Filipino, and Japanese.

The somewhat higher weight of male babies is reflected in the percentage premature by sex using the weight criterion. Each race, except Puerto Rican, showed at least a slightly higher percentage of females premature than males (Table 8). In the case of Puerto Ricans, this tendency was reversed; 11.9 per cent of the males and only 8.6 per cent of the females were premature.

TABLE 8.—*Percent of Single Live Births Weighing 2,500 Grams or Less at Birth by Sex and Race, Territory of Hawaii, 1952-1953.*

RACE	MALE	FEMALE
All races	6.8	7.6
Hawaiian	8.4	10.5
Part-Hawaiian	6.6	6.8
Puerto Rican	11.9	8.6
Caucasian	6.3	6.5
Chinese	5.7	7.0
Japanese	6.1	7.3
Korean	3.3	7.5
Filipino	10.5	12.7

All data in this section indicating birth weight distribution refer to single live births occurring during 1952 and 1953. The two years were combined in order to produce significantly large numbers of cases in detailed breakdowns.

Influence of Birth Weight on Infant Mortality

The data in Table 9 indicating infant death rates (the number of deaths under one year per 1,000 births) by birth weight and race were taken from annual reports of the Territorial Health Department for the years 1951-1954. The rates are based on the number of births and the number of infant deaths which occurred during the four-year period in the same way that annual infant mortality rates are usually calculated. This method includes at the beginning of the period a few infant deaths of children born the previous year and at the end of the period it fails to include a few infant deaths of children born during the period.

A somewhat more accurate method, especially for categories containing small numbers, would have been to base the rates only upon matched births and deaths.

As indicated in Table 9, the chances of survival among infants less than one year of age appears closely related to birth weight. Among babies weighing 2,500 grams or less, the infant death rate averaged 17 times greater than among those in weight groups over 2,500 grams; i.e., a rate of 154.8 compared with only 9.4.

By race, the rates in the premature group varied from 121.4 for Puerto Ricans to 180.3 for Hawaiians and in the mature group from only 6.1 for Chinese to 34.2 for Hawaiians. In the mature category, as for general infant mortality, the Filipinos had the next highest rate (13.3) after the Hawaiians. In the premature category, however, the Filipino rate was less than the average and sixth in magnitude among the eight races specified.

It is of note that the races probably averaging smaller stature—i.e., Filipinos, Puerto Ricans, and Japanese—showed lower infant death rates in the

premature group than the larger Hawaiians, part Hawaiians, and Caucasians. This may mean that the smaller people naturally give birth to somewhat lighter weight babies, so that in the weight grouping of 2,500 grams or less they have a higher proportion of more mature children who have better chances of survival.

Differences between premature and mature infant death rates varied markedly among the races. For example, for Hawaiians the premature rate was only five times greater than the mature rate whereas for Chinese the premature rate was 29 times greater. Similarly, infant death rate differences (between premature and mature) were much less for Filipinos and Puerto Ricans than for Caucasians and Koreans.

Where the differences are largest, it seems probable that prematurity is more likely to be the chief factor in infant mortality; on the other hand, where differences are relatively small, other potent factors additional to prematurity, such as inadequate medical or home care, are operating to cause infant deaths.

Minimum and Optimum Weight Groups

Of children weighing under 1,500 grams, only 244 out of a thousand survived one year (Table 9). In the next higher weight class (1,501-2,000 grams), the likelihood of survival increased more than three times, to 814 per 1,000. In the highest group of the prematures (2,001-2,500 grams), the rate of survival was 955 per 1,000.

From this dividing point between premature and mature, mortality continued to decrease, but much less steeply, up to the range 4,001-4,500 grams, which appeared to be the optimum weight group for survival considering all races as a whole. Only 4.8 per 1,000 died in this range before one year of age.

By race, part Hawaiians and Japanese definitely had their lowest rates in this group of 4,001-4,500 grams (Table 9). On the other hand, Filipinos had their lowest rate in the far lighter group of 2,501-3,000 grams. For Caucasians, no deaths under one year were reported during the four-year period in either the 4,001-4,500 group or in the next higher group, 4,501 grams and over.

As to the other four races specified, small numbers of reported births preclude definite statements as to the optimum weight group for survival. However, on the basis of data available, it appears likely that the lowest infant death rate for Hawaiians is in the weight group 3,501-4,000 grams; for Puerto Ricans and Koreans in the generally optimum group of 4,001-4,500 grams; and for Chinese in the relatively low weight group of 3,001-3,500 grams.

Directly above the generally optimum weight group of 4,001-4,500 grams, the overall rate increased about five times to 25.9, indicating that life for unusually large babies is more hazardous than for those in the more normal weights from 2,501-4,500 grams. This is in line with the observations of obstetricians and the findings of other studies dealing with infant deaths by weight.

From Table 9, it appears that in the highest weight group, 4,501 grams and over, Filipino babies have the highest mortality and Caucasians the lowest. The numbers of reported births in this weight group for Hawaiians, Puerto Ricans, Chinese, and Koreans were too small for the calculation of reliable rates.

Summary

1) In recent years, the premature* infant death rate in Hawaii has remained approximately constant, with no discernible upward or downward trend.

* As used here, "premature" signifies infants weighing 2,500 grams or less at birth.

TABLE 9.—*Infant Death Rates*[a] *by Race and Birth Weight, Territory of Hawaii, 1951-1954.*
(Source: Annual Reports of the Territorial Department of Health)

RACE	TOTAL[b]	BIRTH WEIGHT									
		2,500 *grams or less*	2,501 *grams or more*	1,500 *grams or less*	1,501-2,000 *grams*	2,001-2,500 *grams*	2,501-3,000 *grams*	3,001-3,500 *grams*	3,501-4,000 *grams*	4,001-4,500 *grams*	4,501 *grams or more*
All races	22[c]	155	9	756	186	45	13	8	8	5	26
Hawaiian	50	180	34	[d]	[d]	46	50	41	14	29	[d]
Part-Hawaiian	26	178	12	815	209	44	18	10	10	7	31
Puerto Rican	23	121	9	539	182	57	23	53	3	0	[d]
Caucasian	20	170	7	722	169	58	14	7	5	0	0
Chinese	20	175	6	871	175	63	13	1	6	10	[d]
Japanese	17	124	8	756	153	32	9	7	8	6	43
Korean	19	173	9	[d]	[d]	114	10	10	5	0	[d]
Filipino	30	145	13	719	226	37	10	15	14	15	67
Other races	27	256	9	[d]	[d]	138	10	13	14	0	0

[a] The number of deaths under one year per 1,000 reported births in each weight group.
[b] Includes 135 births and 63 infant deaths for which birth weight was unknown.
[c] This overall rate is based upon 62,402 births and 1,373 infant deaths.
[d] The number of reported births in this category was less than 12.

2) The general infant mortality rate trend is downward.
3) Statistics published by the National Office of Vital Statistics indicate that the percentage of prematures, as determined by birth weight, is slightly greater in Hawaii than in the country as a whole.
4) Among Caucasians only, the percentage premature in Hawaii is greater than the national average; on the other hand, among non-Caucasians as a group (with Japanese predominating) the percentage premature is markedly less in Hawaii than for non-Caucasians in the country as a whole (with Negroes predominating).
5) In line with general infant mortality rates, the neonatal death rate of prematures in Hawaii for both Caucasians and non-Caucasians is less than the national average. For non-Caucasians, the rate is strikingly lower —140.4 deaths per 1,000 premature births compared to 173.7 in the country as a whole.
6) The median weight of single born infants in Hawaii during 1952 and 1953 was 3,225 grams. Among the various races, Caucasians had the highest median weight (3,305 grams) and Filipinos the lowest (3,083).
7) For each race, the modal weight class (single births only) was 3,001-3,500 grams. Symmetry around this peak varied considerably by race.
8) Less than one per cent of all the single births studied weighed less than 1,500 grams; similarly, less than one per cent weighed more than 4,500 grams.
9) Koreans had the lowest percentage of single births in the premature class (5.3 per cent) and Filipinos had the highest (11.6 per cent).
10) As a group, Koreans, Caucasians, Chinese, part Hawaiians, and Japanese were markedly lower in the percentage premature than Hawaiians, Puerto Ricans, and Filipinos.
11) Male babies of all races averaged somewhat heavier than females and each race, except Puerto Ricans, had a slightly higher percentage of females than males in the premature class.
12) During the period 1951-1954, the infant mortality rate for single and multiple births combined was 17 times greater among prematures than for heavier weight babies.
13) The difference between mortality rates of premature and those not premature was greatest for Chinese, Koreans, and Caucasians and least for Hawaiians, Filipinos, and Puerto Ricans. Where differences between the two rates are greatest, prematurity is more likely to be the major factor in causing mortality.
14) The races probably averaging smaller stature —i.e., Filipinos, Puerto Ricans, and Japanese—had lower death rates among prematures than did the larger Hawaiians, part Hawaiians, and Caucasians.
15) The generally optimum weight group for survival—i.e., the weight showing lowest mortality rates—was 4,001-4,500 grams, except that it was decidedly lower (2,501-3,000 grams) for Filipinos.
16) Of infants weighing 1,500 grams or less at birth, only 244 per 1,000 survived one year of life.
17) The average death rate among infants weighing more than 4,500 grams was five times greater than in the optimum weight group of 4,001-4,500 grams. Of those weighing over 4,500 grams, Caucasians appeared most likely to survive and Filipinos least likely to survive.

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REPORT FROM THE DEMONSTRATION PREMATURE INFANT CENTER OF ST. FRANCIS HOSPITAL

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The survival among 1,010 premature infants at the St. Francis Hospital Premature Center compares favorably with that reported elsewhere, and no retrolental fibroplasia occurred during 1955.

IN THE fiscal year 1946-1947, 37.5 per cent of all infant deaths in Hawaii were attributed to prematurity. During the same fiscal year, the rate for the city of Honolulu was higher than that for Hawaii as a whole, 42.1 per cent of all infant deaths in Honolulu being attributed to premature birth.



DR. KOBAYASHI

Recognizing a need to improve the methods of care of premature infants in the community, St. Francis Hospital and the Bureau of Maternal and Child Health of the Department of Health established a Demonstration Premature Infant Center as an integral part of the hospital. This was made possible through the coordinated efforts of the hospital, physicians of the community, and the Department of Health. It was financed partly by St. Francis Hospital and partly by funds from the U.S. Children's Bureau under the Social Security Act. It was one of a variety of special demonstration projects being established or already established in various parts of the nation. It was hoped that such projects would produce a considerable pool of knowledge and that this knowledge would be instrumental in providing better care for prematurely-born infants.

A detailed plan for the Demonstration Premature Infant Center was formulated in October, 1947, and on January 1, 1948, the center opened with Dr. Francis D. Nance as medical director. Other pediatricians who have served as medical directors are Duke Cho Choy, W. T. Chock, Thomas Mar, John H. Peyton, and Clifford K. Kobayashi. The medical supervision of the center was assigned to pediatricians with special training in the care of premature infants. The director was responsible for establishing specific medical and nursing policies and training of residents and nurses in the care of premature infants. He also served as a consultant to all physicians who had premature infants being cared for in the center. The nursing staff, with a supervising nurse specially trained in the care of premature infants, was assigned only to the premature nursery and was not allowed to rotate to other parts of the hospital. A total of about 200 student nurses, 35 graduate nurses, and 20 interns and residents received training and experience in the care of premature infants in the center.

On December 31, 1955, funds from the Children's Bureau were discontinued, and St. Francis Hospital assumed full responsibility for the Center.

Premature Nursery Procedures

Almost all infants are placed in Gordon-Armstrong or Isolette incubators in a high-humidity, high-oxygen atmosphere for at least 24 hours or until they are able to maintain their own body temperatures without wide fluctuations. The routine use of oxygen was discontinued during the latter part of 1954, when it became obvious that the incidence of retrolental fibroplasia was directly related to its vigorous routine use.

At the time of admission all infants, unless in critical condition, are weighed and five milligrams of vitamin K is given intramuscularly. Feedings are withheld for 12 to 72 hours, depending on the size and condition of the infant. Dried half-skimmed milk with five to seven per cent dextrin-maltose is fed to all infants by gavage or nipple as tolerated, and a change is made to evaporated milk formulas a few days prior to discharge. Multiple vitamin preparations with 50 milligrams of ascorbic acid are given daily starting on the second or third day of life.

Prophylactic antibiotics are used at the discretion of the medical director, depending upon the conditions of labor, delivery, and subsequent handling of the infants prior to admission. As a

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rule, we have been conservative in the use of antibiotics prophylactically, and prefer to use them to combat active infection.

Infants are discharged when their weights reach 2,500 grams. All mothers are thoroughly instructed several days prior to discharge and are allowed to participate in feeding and handling their infants.

Results

A total of one thousand and ten (1,010) prematurely-born infants have been admitted to the Center. Of the total, six hundred sixty-two (662) were born in St. Francis Hospital and three hundred forty-eight (348) were born in other hospitals or at home. Table 1 shows the over-all mortality by weight groups. Correction is made for infants weighing less than 1,000 grams, generally conceded to be non-viable from a physiologic standpoint.

TABLE 1. *Over-all Mortality by Weight Groups*

WEIGHT GROUPS IN GRAMS	NO. OF LIVE BIRTHS	NO. OF DEATHS	MORTALITY PER CENT
2,500-2,001	474	22	4.6
2,000-1,501	308	45	14.6
1,500-1,001	151	68	45.1
Under 1,000	77	73	94.8
TOTAL	1,010	208	

Over-all mortality rate: 20.6 per cent
Corrected mortality rate: 14.5 per cent

Table 2 shows the mortality by weight groups of those infants born in St. Francis Hospital.

TABLE 2
Mortality by Weight Groups: Born in St. Francis Hospital

WEIGHT GROUPS IN GRAMS	NO. OF LIVE BIRTHS	NO. OF DEATHS	MORTALITY PER CENT
2,500-2,001	384	12	3.1
2,000-1,501	167	21	12.6
1,500-1,001	64	37	57.8
Under 1,000	47	47	100.0
TOTAL	662	117	

Mortality rate: born in St. Francis Hospital: 17.7 per cent
Corrected mortality rate: 11.4 per cent

Table 3 shows the mortality by weight groups of those infants born outside of and transferred to St. Francis Hospital.

TABLE 3. *Mortality by Weight Groups: Born Elsewhere*

WEIGHT GROUPS IN GRAMS	NO. OF LIVE BIRTHS	NO. OF DEATHS	MORTALITY PER CENT
2,500-2,001	90	10	11.1
2,000-1,501	141	24	17.0
1,500-1,001	87	31	35.6
Under 1,000	30	26	86.7
TOTAL	348	91	

Mortality rate of infants born elsewhere: 26.1 per cent
Corrected mortality rate: 20.4 per cent

The data in Tables 2 and 3 are interesting in that, although the over-all mortality rate of those born in St. Francis Hospital (17.7 per cent) was lower than of those born elsewhere (26.1 per cent), we did not do so well in the weight groups 1,500-1,001 grams and under 1,000 grams. Explanation is difficult because many of the infants transferred to the center were in critical condition, suggesting that the mortality rate in those weight groups should have been higher rather than lower.

TABLE 4
Mortality Rate During the First 24 Hours After Birth

WEIGHT GROUPS IN GRAMS	NO. OF LIVE BIRTHS	NO. OF DEATHS IN 1ST 24 HOURS	MORTALITY PER CENT
2,500-2,001	474	5	1.1
2,000-1,501	308	16	5.1
1,500-1,001	151	45	29.8
Under 1,000	77	49	63.6
TOTAL	1,010	115	

Over-all mortality rate: 11.4 per cent

Table 4 shows a breakdown of the mortality rate during the first 24 hours, and Table 5 after the first 24 hours after birth.

TABLE 5
Mortality Rate After the First 24 Hours After Birth

WEIGHT GROUPS IN GRAMS	NO. OF SURVIVALS	NO. OF DEATHS AFTER 24 HOURS	MORTALITY PER CENT
2,500-2,001	469	17	3.6
2,000-1,501	292	29	9.9
1,500-1,001	106	23	21.6
Under 1,000	28	24	86.0
TOTAL	895	93	

Over-all mortality after 24 hours: 10.4 per cent

Table 6 shows the breakdown of mortality rate by birth weight and sex. Girls fared better than boys in this series, presumably because birth weights of girls are less than those of boys of comparable maturity.

TABLE 6. *Mortality Rate by Birth Weight and Sex*

BIRTH WEIGHT IN GRAMS	SEX	NO. OF LIVE BIRTHS	NO. OF DEATHS	MORTALITY PER CENT
2,500-2,001	Male	236	13	5.5
	Female	238	9	3.8
2,000-1,501	Male	163	29	17.8
	Female	145	16	11.0
1,500-1,001	Male	75	38	50.6
	Female	76	30	40.0
Under 1,000	Male	38	37	97.5
	Female	39	36	92.4

A total of sixteen (16) infants developed retrolental fibroplasia—an incidence of 1.5 per cent. It is interesting to find that no cases occurred in 1948, 1952, or 1955. As previously stated, the use of oxygen was reduced to a minimum during the latter part of 1954, which in all probability explains the absence of the disease in 1955. However, the absence of the disease in 1948 and 1952 cannot be explained. A pair of unidentical twins born in 1949 simultaneously developed the disease. Table 7 shows a breakdown of those developing retrolental fibroplasia.

TABLE 7. *Incidence of Retrolental Fibroplasia*

BIRTH DATE	NAME	RACE	BIRTH WEIGHT (gm.)	HOSPITAL OF BIRTH
1. 6-22-49	WB	Cosmopolitan	1050	Kuakini
2. 4-12-49	CH	Japanese	1680	Kuakini
3. 9-24-49	WM	Japanese	1290	Kuakini
4. 11-28-49	JAP	Korean	1410	Kapiolani
5. 11-28-49	JBP	Korean	1350	Kapiolani
6. 8-19-49	MY	Japanese	1830	St. Francis
7. 9-7-49	GG	Cosmopolitan	2040	St. Francis
8. 2-4-49	SH	Cosmopolitan	900	Queen's
9. 11-9-50	JM	Japanese	1530	Kahuku
10. 12-28-51	EA	Cosmopolitan	1590	St. Francis
11. 10-11-51	CO	Japanese	1350	Kuakini
12. 2-8-53	AD	Cosmopolitan	1590	Molokai
13. 7-22-53	RM	Cosmopolitan	1560	Kapiolani
14. 8-18-53	VC	Cosmopolitan	1650	St. Francis
15. 2-10-54	AT	Japanese	1290	Kuakini
16. 4-4-54	DLA	Cosmopolitan	1200	St. Francis

A total of seventy-five infants were found to have single or multiple congenital malformations. Twenty-three were found to have hemangiomas. Eleven had various types of congenital malformations of the heart and great vessels. Seventy-one had one or more malformations, too numerous to tabulate.

Table 8 lists the various national ancestries represented in this group. Because of the relatively small sample of each group, further breakdown into birth weights and mortality rates was considered to be insignificant. Twenty-one mixtures were represented in the cosmopolitan group.

TABLE 8. *National Ancestries Represented in this Series*

ANCESTRY	NUMBER
Part Hawaiian	273
Japanese	256
Cosmopolitan	151
Filipino	134
Caucasian	96
Chinese	50
Puerto Rican	29
Hawaiian	11
Korean	7
Negro	2
Spanish	1

Discussion

The results at St. Francis Hospital compare favorably with the experience reported by others (see Table 9).

It is our opinion that the most important aspect of the care of premature infants is the nursing care given by a nursing staff trained and interested in the care of these infants. An efficient nursing staff, cooperating with physicians constantly on the alert to improve premature infant care, is an important team in medicine. We believe that rigid individual technics, skillful feeding of appropriate formulas and vitamins, early detection and treatment of infections, the wise use of antibiotics, oxygen, and incubators, refinements in water and electrolyte balance, judicious use of anesthetics and analgesics during labor, and better obstetrical care have all contributed toward improving survival rates.

TABLE 9. *Survival Rates Reported by Various Authors*

BIRTH WEIGHT IN GRAMS	BROCKWAY ET AL 1949	MOTSAY AND HERDOCIA 1951-1955	COREY ET AL 1949-1955	POTTER 1947-1952	ST. FRANCIS HOSPITAL 1948-1955
2,500-2,001	99.7	89.7	97.5	97.5	95.4
2,000-1,501	96.5	68.9	90.8	83.7	85.4
1,500-1,001	64.5	31.3	58.5	50.0	54.1
Under 1,000		12.5	6.4	2.0	5.2

Summary

A total of 1,010 prematurely-born infants were admitted to the Demonstration Premature Infant Center at St. Francis Hospital. The over-all mortality rate was 20.6 per cent with a corrected rate of 14.5 per cent. The mortality rate of infants born in St. Francis Hosptial was lower than that of infants born elsewhere and cared for at the center. The greatest number of deaths occurred during the first 24 hours after birth. Girls fared better than boys. There was an incidence of 1.5 per cent of retrolental fibroplasia. Survival rates at St. Francis Hosptial compared favorably with experience reported by others.

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Case Report

INTESTINAL HETEROPHYIDIASIS

M. A. GLOVER, M.D.,
AND J. E. ALICATA, Ph.D.,† *Honolulu*

Intestinal heterophyid flukes have been reported from various areas including Egypt, the Balkans, the Orient, and Hawaii. The first case in Hawaii, attributed to stellantchasmus falcatus (closely related to heterophyes heterophyes), was reported in 1938[1] from a Japanese patient who suffered severe diarrhea and 18 pounds weight loss following eating raw mullet over a period of time. Subsequent examination of the musculature of 11 mullet from a fish pond and waters of Wailua Bay, Oahu, revealed all to be infected with encysted heterophyid flukes.

The current case is a 57-year-old Irish-Hawaiian woman employed full time as a psychiatric aide. She complained of dizziness on stooping and of headaches for several days in February and in April, 1957. She had consulted neurosurgeons in 1951 for severe headaches and had received temporary relief by right suboccipital novocaine injections. Past history revealed that she was para-5, gravida-6 with one ectopic pregnancy and that she had had a tubal resection in 1929. D & C and radium treatment for hypermenorrhea were done in 1943. She suffered a cerebral concussion when struck by a patient in 1949 and felt that she had been forgetful since this time. Physical examination revealed a normally developed, moderately obese patient although she had been dieting and had lost 25 pounds in the past six months. Although the blood pressure was 170/100, no cardiac enlargement was apparent. The aortic second sound was louder than pulmonic, no murmurs were heard, and heart rhythm was regular. There were no hepatomegaly, edema, or abnormal abdominal or pelvic mass. Plasma cholesterol was 201 mg per cent. Urine showed a few erythrocytes and occasional leucocytes on microscopic examination and positive occult blood (hematest) in 30 seconds. ECG and x-ray chest were normal. Subsequent cystoscopy and retrograde pyelography following control of hypertension with rauwolfia showed a coarsely granular urethra, an extremely rapid drip of very pale urine on catheterization of the left ureter compared with the slower flow of darker urine from the right, and narrowing of one calyx on the left. The over-all impression of previous pyelonephritis with resultant scarring was arrived at. Alcaligenes faecalis was cultured from the urine and disappeared with appropriate antibiotic treatment. A week later she returned to work but complained of headache, backache, and nocturnal abdominal cramps. She developed three or four loose stools the following day, apparently relieved with Pepto-Bismol. The day after this, although stools had become normal and only slight nausea was present, she was asked to have stool study for dysentery organisms and parasitic infection. An unusually alert technician at Territorial Hospital reported ova of heterophyid flukes. Treatment with

(*Continued on page 688*)

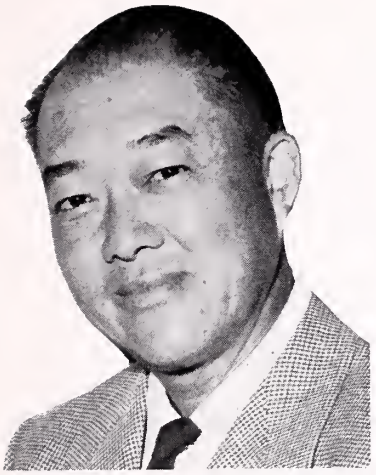


FIG. 1.—Photomicrograph of one of the heterophyid flukes recovered from the feces of the patient following treatment. 100 X.

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[1] Alicata, J. E., and Schattenburg, O. L.: A Case of Intestinal Heterophydiasis in Man in Hawaii, J.A.M.A. 100:1100 (April) 1938.

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† Parasitologist, University of Hawaii.



SAMUEL L. YEE, M.D.

The President's Page

The coming year will certainly witness a far-reaching change in the socio-economic aspect of the practice of medicine—that of government participation in our everyday medical practice. "Medicare" has become a reality although many states such as Ohio and Rhode Island are reluctant to accept it because of its implications. Wisconsin, Indiana, and now Florida have refused to commit themselves to a fee schedule—another way of expressing, perhaps, that they reject the idea.

Medicare type of medicine is being considered for other groups of Federal employees and also for the indigents. How much more of the population it will encompass remains to be seen.

How far Hawaii should go depends upon the expressions of its membership. Your committee on Federal Medical Services, headed by Dr. O. D. Pinkerton, is doing a magnificent job. Many hours are being sacrificed to discuss and formulate policies and to settle disputes. Support this committee and convey to them your ideas. These ideas may shape your own medical practice of the future.

Although the beginning is difficult and uncertain, HMA is gaining knowledge and steadily getting its feet on the ground. On the other hand, government is cooperative and is willing to discuss various aspects of the program. It appears to be sympathetic toward an adequate fee schedule for physicians' services.

In this connection, it might be appropriate to quote Dr. David B. Allman, President of the AMA. In a recent address in Washington to the Health Insurance Association of America Dr. Allman summed up the responsibility of medicine in the financing of health care as follows: "So long as the insurance you promote is consistent with the maintenance of high quality medical care you can be assured that medicine will support you." He said the doctor wants to price his services so they can be purchased through reasonable financing mechanisms "that do not adversely affect the quality of care rendered." The doctor also wants adequate compensation "so as to maintain medicine as a profession to which qualified men can continue to aspire." He told the health insurance executives that these problems must be met by changes in prepayment and insurance mechanisms that permit a reasonable degree of responsibility to be assumed by the patient.

Samuel L. Yee, M.D.

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[EDITORIALS]

Medicare in Hawaii

The Federal Medical Services Committee has been meeting at frequent intervals to review doctors' claims and to consider contract changes. Sessions are apt to last as long as four or five hours. However, the committee believes that the time is well spent because it is imperative that the profession look after its own interests in this or any other Federal program that affects medicine.

The committee feels that many misunderstandings could be avoided and that the doctor's clerical help could be saved unnecessary work, if the doctors would study the provisions of Medicare. It is impossible to collect money from the government on the mere assumption that the service is authorized under Medicare.

It is suggested that all doctors read the fee schedule carefully and with special attention to the following specific items:

a. Section III under EXPLANATION OF DEPENDENTS' MEDICAL CARE ACT 1956. Pages 3 and 4.

b. Section IV MEDICAL SERVICES NOT AUTHORIZED FROM CIVILIAN SOURCES.

It is urgently requested that no procedure be done before the doctor checks his manual of Fee Schedule Allowances to determine whether the claim will be paid by the government. Unless he knows the government's stand, the doctor cannot properly advise his patient whether or not he will be responsible for the charges. The government expects the patients to pay certain medical procedures direct to the doctor. Medicare is not designed to completely cover all of the dependents' medical care. However, when a procedure is listed and a fee is given in the schedule, the doctor must accept that fee as payment in full.

The doctors should instruct their office help to be certain to insert the code number on each claim submitted. This will assure the doctors of receiving full payment for the correct procedure. Where it is obvious that a certain charge for a given procedure will not be authorized, it is best not to include these charges on the Medicare claim forms because this requires review by the Federal Medical Services Committee and holds up payment of the entire claim.

Another cause for delay in processing claims is the omission of the signature of the referring doctor of the claim form submitted by the consultant. To facilitate matters it is desirable that the referring doctor sign a claim form in the proper square (No. 30) and fill in the patient's name. This form can be attached to the accompanying letter or note which the patient takes to the consultant. The consulting doctor will use this signed form in submitting his claim to the HMSA. It should be noted that each doctor must submit a claim. The government will not honor claim forms sub-

mitted by more than one doctor on one form.

There is a provision under section 5b that permits special review for procedures that are not listed or for claims for listed procedures for which the doctor feels he should receive a larger fee because he has spent an unusual amount of time or it was an unusually difficult case. If the doctor wants to avail himself of this provision, he must send an accompanying letter along with his claim and he must also check 29B (rather than 29A) on the claim form before it is submitted to the HMSA.

When a consultant surgeon performs surgery and the referring physician has assisted, there is a standard 20 per cent assistant's fee (Page 9 of the fee schedule). When the referring physician has also rendered part or all of the pre and post-operative care, and he feels he is deserving of more than the 20 per cent fee, the two doctors should arrange their billing by mutual consent before the claims are submitted. The total amount of the two claims cannot exceed the fee allowed plus the 20 per cent.

If any doubt exists relative to the various aspects of Medicare, the Federal Medical Services Committee will be more than willing to help. They would also appreciate hearing from the individual doctors and from the different specialty groups with reference to any part of the Medicare contract which is felt to be inequitable or which is not felt to be acceptable. This should be submitted in writing.

O. D. PINKERTON, M.D.

Care of Prematures

The other day, I was called in as a pediatric expert to care for a newborn two-pound premature. I went through the motions, called a physical examination, then went solemnly in to the mother, shook my head learnedly and gave a grave prognosis. Three days later the infant had made a monkey out of me. She was taking feedings well by nipple, and had started what turned out to be a sustained and uneventful weight gain.

The last two-pound premature subjected to my care died in 48 hours—and I cannot, for the life of me, point out anything that I observed on first examining these two that would have differentiated them, nor anything that I did which affected the outcome.

Dr. Kobayashi's report in this issue gives us some comfort. We apparently are doing about as well by our prematures here in Hawaii as elsewhere, but we still do not do nearly well enough. Too many small prematures die; too many prematures fail to survive the first 48 hours, while we stand by helplessly with no idea of what to do.

When we were in the process of setting up the St. Francis Premature Unit, one thing at least seemed to be sure. We got it on the best of authority. Oxygen, oxygen, and more oxygen was going to save lives. A unit which did not have built-in pipelines of oxygen was hopelessly out of date. We dutifully put in the pipelines—only to find out in a few years that we were probably producing unnecessary cases of retrolental fibroplasia.

And what of the rest of our cherished routines? Perhaps best established of all is the theory that we must withhold fluids for the first 48 hours and let them dry out. It is backed up by impressive statistics (Ah! Statistics!). Then along comes the report of the Rockland Group in Chicago. They not only have statistics, they have blood chemistries—scads of blood chemistries; and if their interpretation of these laboratory findings are correct, we drier-outers are neglecting our patients, allowing them to die of water and electrolyte losses which we should be replacing milliequivalent by milliequivalent. It gives one pause—and yet even *their* results are far from perfect.

When science fails us it is tempting to stray into the field of metaphysics. Is there such a thing in a two-pound human as a will to live? Is this the vital spark that makes one premature thrive while the next one fails? And if so, can someone come up with a give-a-damn pill that will light up that spark when it is lacking?

FRANCIS D. NANCE, M.D.

This is What's New!

New Gadgets: Electronic experts have teamed with British pulmonary physiologists to develop a **gas analyzer.** Air is exhaled into an ionization chamber and blown in an arc through an electromagnetic field. The heavier atoms move peripherally and are quantitatively measured by means of cathode ray oscillograph. (Sir William Harvey Tercentenary Congress, London, [June] 1957.)

* * *

In the United States, the Sanborn Company has devised a little **transistor electrocardiograph machine.** This weighs only 18 pounds and costs less than the standard model. This little rig will take the same leads as the larger, heavier and more expensive machine.

* * *

Tolbutamide, an oral hypoglycemic agent, was released to the pharmacies for prescription ordering on June 1, 1957. Detailed in this country as **Orinase,** it was discovered and synthesized in Germany and has been under clinical trial for the past two years. This sulfonamide has been most effective in older patients with relatively mild diabetes, who cannot be controlled by diet manipulation alone. Patients receiving the drug should be followed closely for evidence of liver or marrow toxicity. Thus far, this appears to be the most promising of any of the oral hypoglycemic agents. (Upjohn Company)

* * *

After performing almost 8,000 periodic health examinations over the past few years, four examining physicians agreed that of any single routine procedure, the proctoscopic examination "detected more potentially serious and yet correctable disease than any other routine procedure." Six per cent of the apparently healthy patients examined had rectal polyps discovered by **proctoscopy.** Some of these proved to be carcinomas after removal. (Ann. Int. Med. [Apr.] 1957.)

Rehabilitation of the **heart patient** should start the moment the patient is stricken with the disease, according to the staff at the Cleveland Work Classification Clinic. The private physician can in about 80 per cent of the patients manage the total program directed towards getting the patient back to maximal functional capacity. The other 20 per cent require a team approach, utilizing occupational therapy and psychiatric, social, and vocational counseling services. Slightly over three-quarters of the patients studied at the Cleveland Work Classification Clinic were able to return to the same vocational and occupational classification. (J.A.M.A. [May 18] 1957.)

* * *

Barry Wood discourses on fever in the June *Scientific American.* The present data pieces together thus: ***granulocytes,*** either damaged or stuck to the walls of a blood vessel in response to an irritant, release a pyrogenic substance. This pyrogen is blood born to the hypothalamic region. Here it acts upon temperature regulatory centers resulting in an increase in temperature. A few details need to be worked out in this hypothesis, for example, why fever in the presence of viral diseases is characterized by granulocytopenia? Nevertheless, it is the most acceptable explanation at the present time.

* * *

Charles Bailey, of Philadelphia, after performing over 1,400 **mitral commissurotomies** for mitral stenosis through the left side of the chest decided to switch to the right-sided approach. After some 200 cases done from the right side, he concludes that in most cases this approach is superior. In addition to approaching the mitral valve from the right side, he has found this approach ideal for **multivalvular surgery.** The tricuspid valve is routinely explored at the completion of all mitral surgery. A number of cases of silent but severe tricuspid stenosis have been found by this maneuver. (J. Thoracic Surg. [Apr.] 1957.)

FRED I. GILBERT, M.D.

Bureau of Medical Economics

It is a pretty well accepted fact that people pay their medical and dental bills last. The tendecy is to pay for material purchases first. How many times have you heard a patient say, "Thank goodness, we have all our bills paid off now, except the doctor. We will start paying him next month."

The Bureau feels that the following information used together with the sample collection letters should help increase your collection rate.

1. **Be certain that you itemize the charges on the original bill and take great care to be accurate. This is important.**
2. **Bill every patient monthly. Statements should arrive at the patient's home on either the first or the last day of the month.**
3. **Send a reminder on the third notice, which is signed by either the doctor or the doctor's secretary.**
4. **Send another reminder on the fourth notice.**
5. **Send a personal reminder on the fifth notice, which is signed by the doctor.**
6. **If the patient ignores these reminders, he is obviously not acting in good faith. At this point a final reminder or the Bureau sticker,* available from the Bureau at no cost, should be used.**

Following are a list of recommended collection and reminder letters:

After three statements have been sent:

Dear.....:

We thought perhaps you have overlooked this statement, which has been charged against your account since.....

After the reminder notice has been sent:

Dear.....:

Since you have not been in to see me for some time, I assume that you and your family are all well.

My bookkeeper tells me that your bill for $50 has been on our books for several months. If you have questions about the charges or have some other reason for not making the payments, please come into the office and talk to me about it. We want to help you in any way that we can.

If these letters above do not evoke a reply:

Dear.....:

Last month I wrote you that your bill for $50 has been on our books for six months. I thought perhaps we might help you. I was very surprised that you did not answer my letter or come into my office to talk to me about it. Won't you please get in touch with me soon so that we can settle this matter?

If the patient has ignored all this correspondence, you should now use the Bureau's collection sticker or the following letter, signed by the doctor:

Dear.....:

We have sent you statements and reminders and written you several times in regard to your bill for $50, which has been due for the past six months. Since we have not heard from you, we have no course other than to turn the account over to a collection agency. If we do not hear from you within the next ten days, all further contacts in regard to this bill will be made by a representative of the agency.

In the following quotation from "The Office Assistant" by Frederick and Towner, the dangers to avoid in collection letters and notes are pointed out. They say:

Use care and thought in designing your collection letters. Avoid such stilted phrases as "I feel sure you must have overlooked the last statement," and "I am disappointed that you have not paid this account." Try to use as few "I's" and "me's" and "my's" as possible. Here's a phrase that is poor collection technique: "In glancing over the accounts, I find that you have not made a payment for several months." This indicated that you were casually looking over the accounts and to your great surprise you found that the patient owed money. The patient's natural reaction is, "What kind of books does that doctor keep?"

It is also poor taste to make the doctor appear as a martyr by stating that "In order to meet our bills, it is necessary for you to pay your account." The patient is well aware of the fact that payment or non-payment of his particular acocunt will not make or break the doctor financially. Also, avoid "biological blackmail" of patients by avoiding such phrases as, "When you needed the doctor, he came to your aid. Now won't you please return this courtesy?"

In some offices stickers with such phrases as "Please" and "Payment Past Due" are attached to statements as collection devices. They are impersonal and undignified, and it is best not to use them.

In an article entitled "Test Your Collection Psychology" which appeared in the June, 1952, issue of *Medical Economics,* James Fuller outlined three important elements in any collection letter:

1. **A brief reminder of the amount owed, along with a direct request for payment.**
2. **An appeal to the debtor's pride and self-respect, which are the mainsprings of human behavior.**
3. **A sincere but informal writing style, as if you were simply talking to the person.**

Fuller says that "if you stick to the friendly, man-to-man approach indicating that 'I know you mean to pay,' you'll get good collection results." And just as important, you'll keep the patients' good will.

R. M. KENNEDY
Executive Secretary

* "The doctors of the Honolulu County Medical Society have adopted a policy whereby past-due accounts are to be turned over to our Bureau of Medical Economics for collection. Since your account is past-due we will be required to turn it over to the Bureau for collection unless settlement is made prior to....."

In Memoriam - - Doctors of Hawaii - - IX

This is the ninth installment of In Memoriam —Doctors of Hawaii.

Seishichiro Muraura

Dr. Seishichiro Muraura was formerly a physician in Wailuku, Maui.

Three days after his return to his native country, Japan, he died of cholera.

"The Independent" of September 25, 1895, reports that "the doctor was highly respected on Maui."

John Atcherley

John Atcherley was born in Manchester, England, on July 31, 1865, the son of John and Sarah (Berkley) Atcherley.

He graduated from Oxford University and Leeds Medical College, Newcastle-on-Tyne, England, and was licensed by "the Royal Court of Examiners of the Royal College of Surgeons" on October 20, 1891. On August 1, 1892, he was accepted as a member of the Royal College of Surgeons. His license to practice in London was issued by the Royal College of Physicians on July 28, 1892. The year 1893 found Dr. Atcherley practicing at the Hospital for Women in London.



Arriving in Hawaii in the same year, the doctor served as surgeon for the "Honolulu Gaol." From 1894 to 1900 Dr. Atcherley was engaged in private practice on the Island of Hawaii, and from 1900 to 1905 he served as government physician for the South Kohala district.

Dr. Atcherley married Mary Haaheo Kinimaka at Kawaihae, Hawaii, on October 27, 1894. The Atcherleys had six children: Sybil, John Francis, Lani Ulwin, Roger Thomas, Samuel Lawrence, and Victoria Elizabeth.

In 1905 the Atcherleys moved to Honolulu where the doctor engaged in private practice for five years. Following this Dr. Atcherley moved to San Francisco where he practiced from 1910 to 1911. From 1912 to 1914 he was surgeon for the Canadian Pacific Railway Company.

Joining the Royal Canadian Navy as Lieutenant Surgeon in 1915, he saw duty on H.M.S. *Shearwater* until 1919. He was awarded the Bronze Star and the Victory Medal for his war services.

He also served on His Majesty's Canadian Ship *Niobe* from 1919 to 1920 and as ship's surgeon for the Royal Mail Packet Company, Halifax, Nova Scotia, until 1922.

The following year saw Dr. Atcherley returning to Honolulu where he engaged in private practice until 1925. From 1925 to 1927 he served as county physician at Ualapue on Molokai and for the following two years he was in private practice on the same island. Returning to Honolulu in 1929, he practiced until his retirement in 1935.

Dr. Atcherley was the author of an article on "Theory as to Origin of Leprosy" published by the *New York Medical Record* on August 6, 1910.

Dr. Atcherley died in Honolulu on November 20, 1940, at the age of 75.

Edward Solon Goodhue

Edward Solon Goodhue was born of American parents in Athabaskaville, Quebec, Canada, on September 29, 1863. He was the son of James and Marian Miranda (Emerson) Goodhue. He was a direct descendant of Benjamin Goodhue, senator for Massachusetts to the first Continental Congress, who drafted the bill for the formation of the District of Columbia. Also through the Goodhue line he was related to Mrs. Calvin Coolidge; the Bigelows of Vermont; Pillsburys of Minnesota; Edna Dean Proctor, the poet; and the late Bertram G. Goodhue, the New York architect. On his mother's side Dr. Goodhue was descended from Ralph Waldo Emerson.

His education was received from tutors, from East Farnhow High School, St. Francis College, McGill University and Rush Medical College, which granted him his M.D. degree in 1892. In 1910 he was granted an honorary A.M. degree and in 1912 an LL.D. He did postgraduate work at the Medical School and Hospital in New York.

In 1892 Dr. Goodhue began his practice in Riverside, California, and remained there until 1895.

He married Lulu Mae Rosser of Chicago on May 25, 1899. The couple had two children, a son, Marion S., and a daughter, Dorothy M.

In 1895 Dr. Goodhue came to Kauai, where he accepted a post as government physician. He also became medical superintendent of the Koloa Hospital and attending surgeon of Malulani and Eleele hospitals. From 1900 to 1904 he was an Acting Assistant Surgeon of the U. S. Public Health and Marine Hospital Service. It was on Kauai that he came in contact with many victims of leprosy and became intensely interested in the study of the disease, publishing a number of papers on the subject.

In 1906 Dr. Goodhue inaugurated the first crusade against tuberculosis in Hawaii and organized the Anti-Tuberculosis Association of Hawaii, with local officers from all the islands.

Dr. Goodhue was a delegate to the International Congress on Inebriety at London in 1909. He was also appointed by President Taft as a delegate to the International Congress on Leprosy which met in Norway in 1909. In that same year he attended his third congress as special representative of Hawaii, appointed by Governor Frear, to the Medico-Legal Congress that met in Brussels.

Always keenly interested in civic and political affairs, Dr. Goodhue was an active worker in the Republican party for many years. As a delegate to the National Republican Convention and a member of the platform committee, he was the first to advocate and draft a provision for woman's suffrage, which was incorporated into the platform.

Through his conference with the President, cabinet members, Senators and Representatives, seeking their aid in the passage of prohibition for Hawaii, Dr. Good-

hue was responsible for obtaining prohibition for the Territory.

In 1919 he wrote and was instrumental in the adoption of the constitution and bylaws of the Civic Improvement Association of Molokai.

Dr. Goodhue was known throughout America, Canada, and England for his numerous articles on scientific and medical subjects as well as for his poetry. He is the author of "Verses from the Valley," 1887*; "Out of the Pigeon Holes," 1899; "Beneath Hawaiian Palms and Stars," 1900; "Hawaii First," 1902; "Within Hawaiian Reefs," 1907; "Songs of the Western Sea," 1911; "All Out of the West," 1911; "The Adequate Care and Punishment of Defectives," 1913; "Under the Silver Moon," 1914; "About the Climate of Hawaii," 1914; "Salt" (Old Doc's Talk), 1914; "Establishment and Maintenance of Racial Characteristics," 1914; "Cycle of Cathay," 1915; "A Few War Verses," 1917; "An Open Letter to the Kaiser," 1917; "On the Reserve," 1920†; and "The Victim," 1921.

Dr. Goodhue was an intimate friend of Theodore Roosevelt, and in 1921 and 1922 he compiled a book of tributes to Roosevelt written by many distinguished contributors in America, France, and England.

Dr. Goodhue died on May 31, 1935, in Honolulu. He was in his 72d year.

He was a Mason, a member of the American Association for the Advancement of Science, American Society of Tropical Medicine, Hawaiian Medical Society, American Medical Association, Medico-Legal Society of New York (vice-president for Hawaii), Hawaiian Historical Society, Author's Club (London), Honolulu Ad Club, Honolulu Press Club, Civic Improvement Association of Molokai (corresponding secretary), and the International Longfellow Society.

James Harvey Raymond

James Harvey Raymond was born in Charleton, New York, on November 23, 1866, the son of Samuel B. and Louisa Raymond. The Raymond family landed in Massachusetts in 1634. His maternal grandfather was Dr. Charles Ball. Dr. C. L. Sieger of Heidelberg, Germany, was his great-grandfather and both were physicians of note.



Dr. Raymond's father suffered business reverses when James was ten, and he was thrown on the world to earn his own livelihood. It was only by dint of perseverance and economy in early manhood that he accumulated enough funds to go to medical school.

His early education was received in grammar school and at Saratoga Institute, New York. He graduated from Rush medical school in 1893, where he spent a year under the preceptorship of Dr. A. C. Cotton, Professor of Diseases of Children.

After graduation, Dr. Raymond was chosen by Dr. E. Fletcher Ingals, Professor of Diseases of the Throat and Chest, as his assistant in his private practice. He remained with Dr. Ingals nearly two years. At the same time he was also appointed by the faculty of Rush College as Instructor in the Principles of Surgery under Dr. John B. Hamilton, Professor of the Principles of Surgery and Clinical Surgery and later Surgeon General of the U. S. Public Health and Marine Hospital Service.

Dr. Raymond came to Hawaii in 1895, going to Koloa, Kauai, to take charge of Dr. J. K. Smith's practice in his absence. Shortly after, while practicing at Wailuku, Maui, he received the appointment of government physician to that district, and also the posts of physician to the Malulani Hospital and to the Spreckelsville and Wailuku plantations. Finally he settled in Honolulu.

On July 30, 1898, Dr. Raymond married Phoebe Dowsett in Honolulu. The couple had one son, James H. Raymond, Jr.

In the early 1900's, Dr. Raymond operated the large Raymond cattle ranch in Ulupalakua, Maui. In 1922 he sold it to Frank F. Baldwin. Dr. and Mrs. Raymond then moved to Menlo Park, California. After the death of his wife in 1929, Dr. Raymond returned to Honolulu to resume his medical practice.

Dr. Raymond was long an active figure in territorial politics and a leader in Democratic activities. He once ran for delegate to Congress and was a candidate for governor. He was often at odds with the "regular" wing of his own party and was regarded as an individualist in politics.

He was appointed a member of the Territorial Board of Agriculture and Forestry in 1935 and resigned a year later.

Dr. Raymond died August 8, 1946, in Honolulu at the age of 80.

Wilbur McConkey

Wilbur Fiske Boggs McConkey was born December 4, 1865, on a farm near Evona, Missouri. He was the youngest of eight children of John and Elizabeth Boggs McConkey.

After elementary and high school in Evona and Albany, Missouri, Wilbur entered the University of Missouri in 1884, but he transferred to the University of Pennsylvania in 1885.

In 1890, in order to be near his ill father, the budding young doctor transferred to Rush Medical Institute in Chicago.

Upon receiving his M.D. from Rush in 1892, Dr. McConkey started practicing in Bethany, Missouri, some 20 miles from his home. Not long after this he took a room at the home of Mr. and Mrs. James Ross Cunningham, and soon fell in love with their oldest daughter, Mary, a school teacher.

While at Rush, Wilbur McConkey and William Goodhue became friends. Dr. Goodhue wrote his friend in Missouri urging him to come to Hawaii to practice. This suggestion was accepted by Dr. McConkey, who arrived in Wailuku in February, 1896.

In August, 1897, Mary Cunningham came out to California, where Wilbur met her. They were married in Alameda on September 2, 1897. They left for Maui at once, arriving by sailing vessel late that month.

After a year in Wailuku, Puunene Plantation needed a physician so the doctor went there for a short time. In a few months, poor health forced Dr. Aiken in Paia to retire and Dr. McConkey took his place there.

Two children were born to the McConkeys: Virginia Elizabeth, on July 23, 1899, and John Ross, on June 16, 1902.

While in Paia, Dr. McConkey was largely instrumen-

(*Continued on page 674*)

* Some sources give the date as 1889.
† Some sources give the date as 1921.

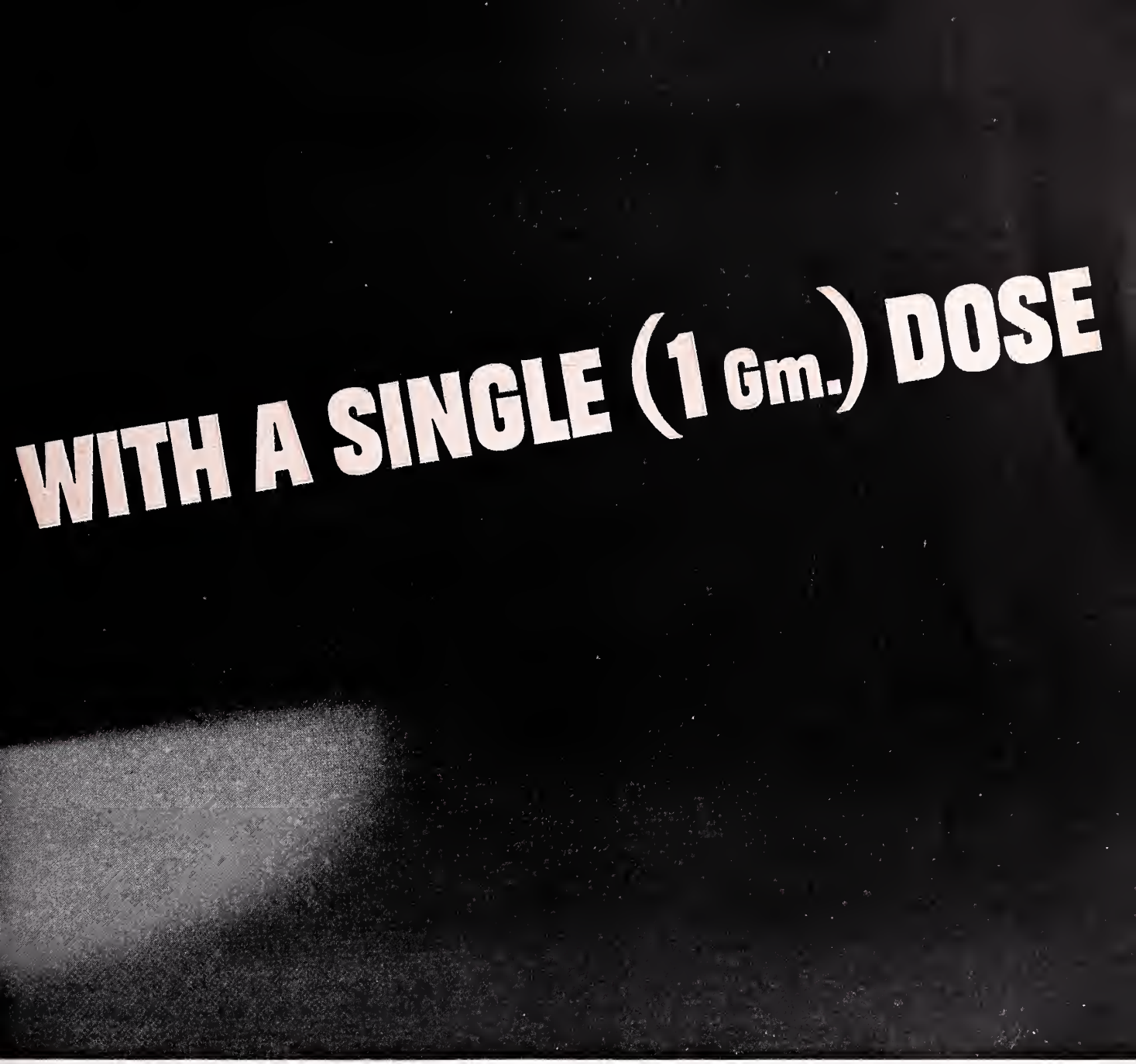
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For greater safety: low dosage, high solubility and slow excretion help avoid crystalluria. **For broad antibacterial effectiveness:** KYNEX is particularly efficient in urinary tract infections due to sulfonamide-sensitive organisms, including E. coli, Aerobacter aerogenes, paracolon bacilli, streptococci, staphylococci, Gram-negative rods, diphtheroids and Gram-



positive cocci. **For convenience:** the low dosage of 1 Gm. (2 tablets) per day offers optimum convenience and acceptance to patients.

Tablets: Each tablet contains 0.5 Gm. (7½ grains) of sulfamethoxypyridazine. Bottles of 24 and 100 Tablets.

Syrup: Each teaspoonful (5 cc.) of caramel-flavored syrup contains 250 mg. of sulfamethoxypyridazine. Bottle of 4 fl. oz.

1. Boger, W. P.; Strickland, C. S.; and Gylfe, J. M.: Antibiot. Med. & Clin. Ther. 3:378 (Nov.) 1956.

KYNEX*

SULFAMETHOXYPYRIDAZINE LEDERLE

*Reg. U.S. Pat. Off.

LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, NEW YORK

Lederle

HMSA—Its Place in the Community

R. B. FAUS, M.D., *Medical Director*

"Without Blue Shield and Blue Cross . . . our hospitals and ourselves would be hard put to render the services that these organizations have made possible . . . many patients who previously would be non-paying patients have had their bills at least partially paid, and I am rather intolerant of the physician who is not a participating member of Blue Shield and who complains when Blue Shield pays the patient and not him directly. I also am intolerant of the physician who in defense of his attitude in not being a participating member says with a loud voice 'Nobody is going to tell me what to charge.' I am outspoken enough to say the physician who takes such an attitude is primarily interested not in service but in money. Today's professional freedom to be a private practitioner of medicine instead of a slave of government is due solely to Blue Shield—the physicians' answer to socialized medicine. Forgive me if I offend, but sometimes the truth hurts, and I am so jealous of the good name and the freedom of our profession."

The above statement by Dr. Elmer Hess, past-president of the AMA, clearly states the convictions of the Blue Shield founders who, during a national depression and in spite of advice by the insurance industry that prepaid medical and hospital care was uninsurable, launched the Blue Shield movement. This great gamble, accomplished through the faith and perseverence of a handful of dedicated physicians and civic minded people has proved to be one of the greatest socio-economic developments, indeed, *revolutions,* of the 20th century.

Today, some twenty years following the birth of prepaid medicine in the Territory, in times of great economic prosperity, many of us are prone to forget, and in some cases decry, this "noble experiment." Our younger doctors have not had to experience the very things which motivated and established Blue Shield. Sickness recognizes no master—even in times when a nation could not afford to be sick. From such trying times was born Blue Shield, fathered by the medical profession and indeed one of our brightest achievements. It cannot be stated too often that our greatest bulwark against socialization, and the answer to providing our community with the economic answer to illness, has been Blue Shield. We must strive to protect and promote our own Blue Shield Plan for Hawaii, HMSA, recognizing that to not do so would leave our profession open to the intervention and dictates of government. Sickness knows no master, and the community will continue to demand the best of our talents regardless of economic cycles. We must be ever prepared to meet this continuing challenge by providing that service and the means whereby most of the cost can be met and that is . . . HMSA, our sponsored Plan.

* * *

Commercial insurance carriers at first refused to write Health and Accident coverage because their actuaries advised them the idea was economically unsound and did not conform to the basic principles of insurance.

It remained for the doctors and hospitals to underwrite the Blue Plans and the idea of prepayment became a reality. The steady, rapid growth of the Blue Plans and proof it could be a sound economical venture almost overnight caused the commercial plans to "buy in" at any price in order to get large groups which they knew to be good risks. This was like skimming the cream off the top; take the good risks, leave the poor actuarial risks and small groups and individuals to the Blue Plans to cover. *Blue Plans* need more than poor risks to make their plan succeed. Blue Plans return 90 per cent of income to members annually in way of *services paid for* to doctors and hospitals. Commercial plans seldom return more than 70 per cent to beneficiaries by reason of the fact they operate for profit and have to pay taxes. Now with a $50.00 deductible and 25 per cent co-insurance factor, they are offering a semi-comprehensive plan. Further the co-insurance factor safeguards not more than 70 per cent loss ratio and a 30 per cent profit.

Prepayment now has become almost universally acceptable. The public, labor, and management demand it. Labor demands full coverage with no co-insurance factor or balance for the laborer to pay. Only a Service Plan can approach such an ideal and its success is directly in proportion to the degree of support given it by the sponsoring doctors. Such a Plan, like a four-legged stool, is strong because of the support given by the doctor, the hospital, the member, and the administration. Cooperation, understanding, willingness to render service, and willingness to meet any necessary deficit is mandatory of each. Weakness in any leg of the stool results in instability of the whole. Integrity on the part of all spells success.

Now that the doctors have proved prepayment is successful, everyone wants to jump on the band wagon for control of the purse strings and the benefit payments. Labor wants its own plan (United Mine Workers and Garment Workers), municipalities want their own plan (Health Insurance Plan of New York), government is being forced by popular demand to enter the field (Medicare, Veterans' Bureau), and civil service employees will be next.

Remember, only doctors and hospitals can render the service the public demands and is willing to pay for in advance:

A fee-for-service plan implies a contract with physicians, at an agreed fee schedule, to render service to members.

A panel of physicians, with a closed staff hospital, contracting to render service on a per capita basis annually is another approach.

To indemnify or reimburse member patients at scheduled amounts for services received and fixed rates at hospitals is the commercial approach.

Another is co-insurance. Fifty dollars, deductible annually before eligibility of benefits is established, then, 25 per cent of the total bill is subsequently paid by member. The balance is paid by the insurance company, up to a maximum of $5,000 or $10,000.

There you have the various ways dollars are assembled to pay for your services. Support the plan in which you have a voice and set the schedule of compensation.

Why not let commercial insurance handle all accident and health schemes? Oregon tried it. Tonsillectomies went down to $10.00 and office calls to 50¢. Henceforth, Oregon Physicians' Service was born and the doctors pay $100.00 to participate.

Book Reviews

Muscle Relaxants in Anesthesiology.

By Francis F. Foldes, M.D., 210 pp., Price $5.50, Charles C. Thomas, 1957.

This book serves as a practical guide for the safe and efficient clinical use of muscle relaxants. It gives the basic chemical, physiological, and pharmacological information necessary for the understanding of the clinical application of muscle relaxants, and serves as a starting point for those interested in pursuing clinical research in problems related to the use of muscle relaxants. This book is not recommended for surgeons, who might gain a little knowledge of what goes on behind the ether screen, and who might therefore spoil the smooth conduct of a normal anesthetic.

GEORGE W. BACHMANN JR., M.D.

Children's Eye Problems.

By Emanuel Krimsky, M.D., 175 pp., illus., Price $6.00, Grune & Stratton, Inc., 1956.

As the title suggests, this book is written for the pediatrician and the general practitioner rather than the ophthalmologist.

Although small, this volume covers comprehensively and concisely the many and varied eye conditions that may be seen in children. The book is illustrated with photographs that demonstrate examination techniques and findings very well.

The approach to the child with an eye problem as a whole, rather than the eye condition alone, is a refreshing one.

This volume is also of value to the nurse, or parent, or the public health worker who works with children with ophthalmological problems.

VERNON K. S. JIM, M.D.

Tumors of the Thymus Gland.

By Benjamin Castleman, M.D., 83 pp., illus., Price $1.00, Armed Forces Institute of Pathology, 1955.

This is a very clear expression with illustrations in color and in black and white of tumors of the thymus. The author's experience on this subject, plus his contact with other experts in this field, has permitted him to set forth a lucid, concise, and understandable picture of the pathology of thymic tumors with all their variations. Of necessity, myasthenia gravis is discussed. This fascicle goes a long way in clearing the confusion which exists in this field without stepping on anyone's favorite theories.

W. HAROLD CIVIN, M.D.

Chemosurgery in Cancer, Gangrene, and Infections.

By Frederic E. Mohs, M.D., 305 pp., illus., Price $13.50, Charles C. Thomas, 1956.

The basic techniques of chemosurgery are found in the first 24 pages of this book. It is written in an interesting manner and is profusely illustrated with excellent photographs which show the carcinomatous lesions before, during, and after the treatments. This makes it easy for one to thumb through the book to learn the indications for chemosurgery.

The second part of the book deals with the treatment of non-cancerous lesions. Many lesions of this group can be treated with greater ease by the average practitioner by the more popular means of excisional removal followed by a microscopic diagnosis.

All physicians should be familiar with the scope of this method of treating external carcinomas for it affords an additional means of therapy for surgical failures and x-ray resistant malignancies.

WAYNE WONG, M.D.

Clinical Psychology.

By Richard W. Wallen, Ph.D., 388 pp., Price $6.00, McGraw-Hill, 1956.

This book was intended to provide an orientation to clinical psychology beyond what is usually found in a college course or text. The author has recognized the need to record and emphasize the difficulty of describing qualities and behaviors which are unique to expert clinicians in the household of psychologists. The clinical philosophy and orientation he elaborates are precisely those characteristics most graduate students lack and which one hopes to develop in them during internship and later supervised training.

With the possible exception of Chapters 8, 9, and 10, which deal with the use of various tests, each chapter unfolds some complex clinical activity in a practical, orderly manner, giving not only orientation toward the process but also elaboration of the steps and subprocesses involved, as well as case illustrations. In his discussions of clinical sensitivity and hypothesis-making, he first disposes of intuition as a basis for inferences, then discusses the elements of attention, orientation and trained, directed observation necessary to develop this "art."

This excellently written book describes in simple, logical terms many of the complexities of the clinical psychologist's role. Reading it can be a unique and profitable experience both for the neophyte and experienced clinical psychologist. Most of the chapters are sufficiently general to be valuable references for trainees in psychiatry and social work.

GEORGE F. HARDING, Ph.D.

Textbook of Pathology (8th Ed.).

By E. T. Bell, M.D., 1028 pp., illus., Price $14.50, Lea & Febiger, 1956.

The eighth edition of Bell's Text Book of Pathology has been thoroughly revised in order to include recent advances in pathology. Treatment of the subject material is orthodox, with the first part of the book devoted to various phases of general pathology followed by a discussion of the pathology of specific organs and systems. Most of the illustrations are good and there are a few color plates to illustrate the blood cells and certain lesions of the pancreas and kidneys. The bibliography, while not extensive, is generally adequate and up to date.

I. L. TILDEN, M.D.

(Continued on page 677)

Notes and News

DOCTORS

Addressed . . .

. . . public administrators

Dr. E. W. Haertig spoke on "Stress in Human Relationships" April 9 to the Hawaii Chapter, American Society for Public Administration.

. . . property owners

Dr. Lyle G. Phillips spoke on April 9 to the Honolulu Property Owners Association on "Communist Influence on the Economic and Political Life in the Islands."

. . . televiewers

Dr. Katherine J. Edgar served as commentator for the film "Human Heredity," the Hawaii Medical Association TV presentation given on KONA May 1.

Drs. George W. Henry, Andrew C. Ivy, Jr., Ichiro Nadamoto, and **Warren L. H. Wong** participated in a panel discussion on "Arthritis," shown over the same channel on May 29.

. . . the Hawaiian Academy of Science

Dr. Harold M. Johnson spoke on "Dermal Abrasions for Acne and Other Skin Defects" on April 26.

. . . Mental Health Forum

Dr. Harry Arnold, Jr., and **Dr. Pershing Lo** discussed "Individual Tensions" on May 2 at the Mabel Smyth Auditorium.

. . . International House Association

Dr. William John Holmes chose as his topic "Medical Mission to Asia" when he addressed the Hawaii Chapter of International House on May 12.

Travelers to . . .

. . . Virginia

Dr. Harold Kimata attended the Ear, Nose & Throat meeting at the Gill Memorial Hospital in Roanoke.

. . . Washington, D. C.

Dr. Forrest J. Pinkerton and **Dr. Harold Kimata** attended the Sixth International Congress of Otolaryngology.

. . . New York

Dr. G. M. Halpern visited Kodak's Rochester plant to check on new medical photography processes which will be used in Queen's new photography department.

. . . the Orient

Dr. L. Q. Pang visited Formosa, Manila, Singapore, Bangkok, Penang, Hong Kong, Angkor Wat, and Japan. While in Tokyo he conferred with several doctors on plastic surgery of the nose.

. . . Switzerland

Dr. Min Hin Li traveled to Lucerne to represent Hawaii at the International Rotarian Meeting.

Dr. Richard K. C. Lee attended the Tenth World Health Assembly held in Geneva as one of 19 United States Delegates sent at Federal expense.

Cited . . .

. . . by the University of North Dakota

Dr. Min Hin Li was honored at a special dinner on April 23 at the Grand Forks Country Club and was proclaimed "The First Honorary Citizen of North Dakota" by former governor Norman Brunsdale. Dr. Li was also given a life membership in the Blue Key National Honorary Fraternity of the University of North Dakota.

New Offices . . .

. . . uptown

Dr. Yutaka K. Yoshida announces his association with Clinical Associates at 1010 South King Street.

Dr. Ichiro Nadamoto announces the removal of his office to The Medical Arts Building.

. . . in Kaimuki

Dr. Steven Tyau announces the opening of his offcie at 1133 Twelfth Avenue.

. . . downtown

Dr. William Hampden Sage has returned to Honolulu from New Orleans and announces his association with The Fronk Clinic at 1136 Union Street.

. . . in Kailua

Dr. Kenneth Momeyer announces his association with Dr. John R. Sedgwick, Jr., at the Kailua Shopping Center.

Elected

Dr. Robert P. Henderson of Hilo was elected Hawaii's representative to the National Tuberculosis Association for the next two years.

Dr. Hastings H. Walker was elected on May 7 to the governing council of the medical section of the American Trudeau Society of the National Tuberculosis Association.

Visiting . . .

. . . surgeons

Dr. George Crile, Jr., of Cleveland, addressed the Honolulu General Surgical Society Meeting on April 30. His topic was "Some Problems Pertaining to the Treatment of Cancer."

Dr. Jack G. Kerr, Associate Professor of Surgery, Southwestern Medical School, Texas, was the guest speaker at the June 18 meeting of the Hawaiian Academy of General Practice. He chose as his subject "Considerations Affecting Surgical Intervention in Diverticulitis."

Assignments . . .

. . . to National Guard Duty

Drs. Robert B. Faus, Alvin V. Majoska, Peter Kim, and **Rudolph P. Wipperman** were stationed at Schofield for two weeks during the annual National Guard encampment.

. . . to Queen's

Dr. Keith F. O. Kuhlman began his residency in surgery July 1 at The Queen's Hospital.

(*Continued on page 674*)

FRANK LESTER PLEADWELL, M.D.
1872-1957

Frank Lester Pleadwell was born in Taunton, Massachusetts, on August 9, 1872, the son of William Henry and Kate Sophia (Bradley) Pleadwell. He attended the public schools of Taunton, and received his M.D. (cum laude) from Harvard University Medical School in 1896. He became Assistant Surgeon in the U. S. Navy on October 24, 1896, and after attending the Naval Laboratory and Department of Instruction in Brooklyn, he was assigned to duty on the U. S. training ship "Constellation," where he served for four months in 1897; then after a month of temporary duty on the USS "Texas," he joined the USS "Nashville" for two years. During the Spanish-American War he was awarded the Bronze Medal in recognition of his services in the engagement at Cienfuegos. Following this, he was assigned to the Bureau of Medicine and Surgery, Navy Department, Washington, D. C., from August, 1899, to December, 1900.

Then he again went to sea, on the U.S. Flagships "Kearsarge" and "Olympia." From 1903 to 1905 he served at the Naval Dispensary, Washington, D. C. This was followed by two years at the Naval Hospital, Yokohama, Japan; the next three years, in addition to serving as Assistant in the Bureau of Medicine and Surgery, he was Instructor in Hygiene at the Naval Medical School and President of the Naval Examining and Naval Medical Examining Boards. Another three-year tour of sea duty was followed by three years at the Naval Medical School and Naval Dispensary.

In May 1916, Pleadwell was sent to the American Embassy in London as a Medical Inspector to observe the work of the Medical Department of the British Navy. His numerous reports as a medical observer of the medical organizations of the Navy and Army in England, France, and Italy were of the greatest importance to the U. S. Government.

From the latter part of May, 1917, to the middle of September, he was Medical Aide to Vice Admiral W. S. Sims, Commander, U.S. Naval Forces, operating in European waters. He was considered by Admiral Sims to be "one of the most competent officers of my acquaintance."

On April 20, 1917, Dr. Pleadwell was ordered to join British Naval Units in a test of a scheme to detect the presence of submarines. These "hush hush" tests turned out to be a series of trials carried out in a lake in Wales with trained sea lions as submarine detectors. Pleadwell wrote a very interesting article on these trials which he termed his "most interesting adventure during the War." "A Strange Adventure in Wales," *United States Institute Proceedings,* Volume 50, No. 7, July 1924. For meritorious services rendered the United States during World War I in England, he received a Certificate of Commendation and a Silver Star together with the Medal of Commander, Order of the British Empire (Military Division).

Upon his return to the United States, he was assigned to duty as Medical Officer at the Navy Yard, Norfolk, Virginia, and subsequently, Medical Aide to the Commandant of the Fifth Naval District. By this time (January 8, 1918) he had been promoted to the permanent rank of Captain. Following a year at Naval War College in Newport, Rhode Island, he became Fleet Surgeon and Aide on the staff of the Commander-in-Chief of the Atlantic Fleet (USS "Pennsylvania"). He returned to the Bureau of Medicine and Surgery in Washington in June, 1921, where he remained until 1924.

In 1925, Dr. Pleadwell came to Hawaii in command of the Naval Hospital at Pearl Harbor and as District Medical Officer. Here he remained until 1928, when he was assigned to the command of the Naval Hospital in Boston until his retirement from the Navy in 1929. In December, 1931, he returned to Honolulu with his wife, Laura Mell Pleadwell, to make his home. In the course of his long career as a distinguished naval officer, Pleadwell attended many national and international congresses either as a delegate of the United States Navy or as an individual. He held membership in several medical organizations: Member, Association of Military Surgeons (1900—President 1921-22); Fellow, American Medical Association (1906); Fellow, American College of Surgeons (1917); Fellow, American College of Physicians (1923); Honorary Member, Honolulu County Medical Society.

Frank Lester Pleadwell was a widely cultivated man in the old tradition. He had many varied interests apart from medicine and Navy affairs. His particular interests were in literary fields; he was for many years a well-known collector of books and autographs; as an author his writings were numerous in the fields of Naval medicine, Naval history and biography, and medical history. His many professional and biographical articles were contributed to *Military Surgeon, Navy Medical Bulletin, Annals of Medical History* and other periodicals. Additionally, he wrote two books, "The Life and Works of Edward Coote Pinkney" 1925, with Professor T. O. Mabbott; and "The Life and Works of Joseph Rodman Drake," 1935.

From the time of his retirement in 1931, he was free to devote all of his time to his great love of literature. His acquaintance with litterateurs throughout the United States and Europe was extremely wide and he kept up an extensive correspondence almost to the end.

From a personal standpoint, I may say that Frank Pleadwell was one of the finest men that I have ever known, a man whom I have always held in highest esteem as a splendid physician, a distinguished man of letters, and a fine character. As President Theodore Roosevelt said of him in a letter dated August 18, 1916, to Sir Arthur Lee, England: "This will introduce to you Dr. F. L. Pleadwell, Surgeon in the U. S. Navy, a friend of mine and of my family's. Under Surgeon General Rixey, he was in attendance upon us in the White House. He is in the best sense of the word an American officer and gentleman, also trustworthy in every sense. (s) Theodore Roosevelt."

We extend deepest sympathy to Dr. Pleadwell's widow, Laura Mell, to his sister, and to his daughter by a former marriage.

H. H. WALKER, M.D.

County Society Reports

Kauai

The regular monthly meeting of the Kauai County Medical Society was called to order on Tuesday, April 2, 1957, at 7:45 P.M. at the Wilcox Memorial Hospital Library by Dr. Wade. Visitors were Dr. Morton Berk, Mrs. Inouye, and Joe Veltmann from HMSA. Dr. Berk talked on heart problems of the Heart Association.

* * *

The regular monthly meeting of the Kauai County Medical Society was held on May 7, 1957, at the Wilcox Memorial Hospital Library by Dr. Wade. One visitor, Dr. Winter, was present.

Letters were read regarding the Kaiser Medical Plan, the proposed hospital in Kailua, and Senate Resolution 47. No action was taken.

Dr. Kim reported if there are any tumors found in the recent chest survey, Dr. Walker is to be contacted at Leahi Hospital where they will do a diagnostic work up if requested. Dr. Kim reported on the House of Delegates meeting.

The movies, "The Medical Witness" and "The Case of the Doubting Doctor," were shown.

SAM R. WALLIS, M.D.
Secretary

Hawaii

The Hawaii County Medical Society dinner meeting was held on April 17, 1957, at the Lanai Restaurant. Members present were Drs. Asami, Crawford, Helms, Kasamoto, Leslie, Matayoshi, Mitchel, Miyamoto, Oda, Okada, Ota, Oto, Stemmermann, Steuermann, Taniguchi, Wippermann, Wong, Woo, and Yamauchi. Guests present were Dr. and Mrs. George Snively, Dr. Sarvis, and Interns Drs. Kumagai, Chung, and Ueki.

Dr. Robert Miyamoto, president, called the meeting to order at 8:25 P.M. He presented a request by Miss Betsy Baylor, a member of the Citizens' Pure Water Committee, to have a member of the Committee address our Society. Dr. Crawford moved that this matter be tabled. Dr. Stemmermann seconded the motion and the membership voted unanimously in favor of it.

The rest of the evening was devoted to a very interesting discussion on liver disease and treatment by Dr. George Snively, Director of the Medical Department of the Sacramento County Hospital.

* * *

The Hawaii County Medical Society Dinner-Meeting was held on May 11, 1957, at the Hilo Hotel. Guests present were Drs. James Dennis, Wilson, Sarvis, Marcarelli, and interns Ueki and Chung.

Dr. Wilson and Dr. Dennis presented interesting and informative talks on "Parenteral Fluid Therapy" and on "Management of Diarrhea in Infants" respectively.

A business meeting was called to order by Dr. Miyamoto. The application for membership to the Hawaii County Medical Society and an application for participating physician membership in HMSA by Dr. Frank Tabrah were passed by the Board of Censors and were unanimously approved by the membership. The proposed amendments to the Constitution for the creation of an Inactive Membership and for raising the Society annual dues from $50 to $55 were read by Dr. Miyamoto for consideration. A motion to accept the amendments was unanimously approved by the membership.

Dr. Okumoto, Chairman of the Polio Committee, reported that 1,928 children, under twenty, and pregnant women were given polio shots in May. Last month, 2,030 were given the shots. Dr. Okumoto also reported on the meeting held in Honolulu with the various community leaders and representatives from the Public Service Committee of the Honolulu County Medical Society for the purpose of formulating plans to further the polio immunization program.

RICHARD M. YAMAUCHI, M.D.
Secretary

Maui

The regular meeting of the Maui County Medical Society was held at the Central Maui Memorial Hospital Library on March 12, 1957. Guests present were Doctors Haff, Reichert, and Otsuka.

Dr. William Patterson, Chairman of the Program Committee, introduced Dr. Reichert, who gave us a very interesting talk on head injuries.

Dr. Patterson, Councillor to the HMA, reported to the Society on the following:

1. The expenses up to $10.00 a day, plus airplane fare to be paid to the Councillors by HMA.
2. The Legislative Committee to be appointed every two years and to meet with the Legislators.
3. The Executive Secretary of the HMA to attend both HMA and Honolulu Medical Society meetings.
4. The $25.00 dues of the HMA to be prorated on a quarterly basis hereafter.

It was moved by Dr. Sanders and seconded by Dr. Underwood to approve the Councillor's report. Motion carried.

It was moved by Dr. Sanders, seconded by Dr. Ferkany, that our Constitution and Bylaws be amended permitting our annual meeting be held in December and the officers to take office in January. Motion carried.

Dr. Underwood moved, seconded by Dr. Iaconetti, that all honorary members be designated as life members of the Society.

Committee reports on the HMSA Community Plan Group Insurance on rates and income clause; recommendation:

1. HMSA should increase their monthly rates for the Community Plan Group Insurance sufficiently to allow for the 20% deduction now in force. It was moved by Dr. Sanders, seconded by Dr. Underwood, to accept the recommendation.
2. The maximum income clause should be from $5,000 to $7,500, rather than the $7,500 to $10,000 as proposed by HMSA.

It was moved by Dr. Sanders, seconded by Dr. Underwood, to accept recommendation #2.

Nominating Committee reported the following for officers for the year 1957-58 beginning in July, 1957.

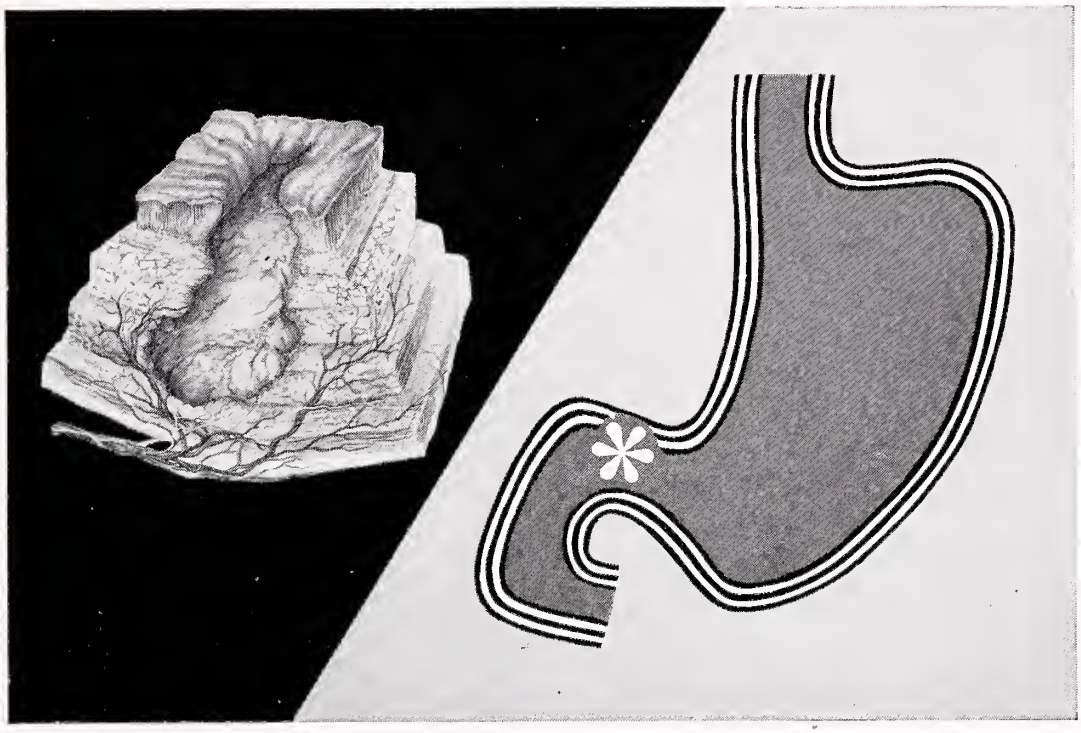
President—Dr. Mamoru Tofukuji
Vice-President—Dr. Lester Kashiwa
Secretary-Treasurer—Dr. Joseph Ferkany

Dr. Sanders moved and it was seconded by Dr. Tompkins that the nominations be closed. Delegates were Dr. Burden and Dr. Tong, the alternates to be chosen by the president prior to the meeting.

Dr. Burden invited the Maui County Medical Society to have their next meeting at Haliimaile as guests of the Maui Pineapple Company.

MAMORU TOFUKUJI, M.D.
Secretary

BROAD ANTICHOLINERGIC BLOCKADE



Pro-Banthine® Relieves Pain, Accelerates Peptic Ulcer Healing

The efficiency of Pro-Banthine (brand of propantheline bromide) in inhibiting the chemical substance which mediates parasympathetic gastric activity explains the success of the drug in ulcer therapy. Pro-Banthine blocks acetylcholine at both the ganglia and parasympathetic effector sites. This dual action controls excess neural stimulation of both gastric secretion and motility.

The therapeutic benefits of this anticholinergic blockade consist, as many clinical investigators have noted, in prompt relief of ulcer pain and pronounced acceleration of ulcer healing.

The suggested initial dosage is one 15-mg. tablet with meals and two tablets at bedtime. Two or more tablets four times a day may be indicated in severe manifestations. G. D. Searle & Co., Chicago 80, Illinois. Research in the Service of Medicine.

SEARLE

101ST ANNUAL MEETING HAWAII MEDICAL ASSOCIATION

LIHUE, KAUAI
May 2 through May 5

The annual meeting for the one hundred and first year of corporate existence of the Hawaii Medical Association was held on Kauai. The following program was presented:

SCIENTIFIC PROGRAM

PANEL DISCUSSIONS

Jaundice
Moderator: Dr. S. R. Wallis.
Panelists: Drs. James Wilson, Harold Civin, Roy Tanoue, and C. S. Brown.

Management of Severe Multiple Injuries and Mass Casualties
Moderator: Col. Warner F. Bowers.
Panelists: Drs. Ralph B. Cloward, Robert B. Faus, B. Allen Richardson, and Herbert Chinn.

Pre and Postoperative Sedation
Moderator: Dr. Paul Gebauer.
Panelists: Drs. W. S. You, G. W. Bachman, Clifford K. W. Chock, Shoyei Yamauchi, and James W. Cherry.

Acute Pediatric Problems
Moderator: Dr. Duke Choy.
Panelists: Drs. James Dennis, Clifford Kobayashi, Raid B. Chappell, F. D. Nance, and Herbert F. Philipsborn, Jr.

PAPERS

Presidential Address
Webster Boyden, M.D.

Adventures in Pediatrics
James Dennis, M.D.

Thoroughness in Diagnosis
James Wilson, M.D.

Case for Tumor Registries: Report on Gastric Cancer, End Result Study, 1944-51
Grover Batten, M.D.

Appendiceal Oxyuriasis
Eichi Masunaga, M.D.

SOCIAL PROGRAM

No Host Cocktails and Dinner, Thursday evening, Coco Palms
Cocktails and Dinner, Friday evening, Kauai Inn
Cocktails and Annual Banquet, Saturday evening, Kauai Inn
Breakfast, Sunday morning, Wailua Golf Club (courtesy of Pfizer Laboratories)
Golf Tourment, Sunday morning, Wailua Golf Club
Picnic for doctors and their wives, Sunday noon, Kauai Yacht Club



THE WINNERS

Dr. and Mrs. Samuel R. Wallis enlist the aid of their son, Sam, Jr., to help them carry off their trophies.



1957 contenders for the Hawaii Medical Association's Annual Golf Tournament held at the Wailua Golf Club.

MEETINGS

Council, Thursday evening, Coco Palms Hotel
House of Delegates, Friday morning, Parish House
Woman's Auxiliary, Executive Board and Auxiliary Delegates meetings, Friday morning, Kauai Inn

Annual Membership Meeting, Friday evening, Kauai Inn

MINUTES OF COUNCIL MEETING

Thursday, May 2, 1957, at 9:20 P.M.
Coco Palms Hotel

PRESENT:

Drs. Webster Boyden, Samuel L. Yee, Burt O. Wade, S. Nishijima, H. Q. Pang, Thomas S. Bennett, William B. Patterson, Theodore T. Oto, Clarence E. Fronk, Mr. Richard Kennedy, and Miss Lee McCaslin.

The minutes of the February 21 meeting were approved as circulated.

The matter of granting Mrs. Gueco a leave of absence was discussed.

ACTION:

It was moved and seconded to permit Mrs. Gueco to take this leave without pay. It was further moved that the executive secretary be authorized to secure adequate relief. Both motions were passed.

The budget was outlined by Dr. Pang who pointed out that originally the JOURNAL expense was estimated at $27,000.00 based on the cost of the last issues. After talking with Dr. Arnold he was told that the JOURNAL expenses would be pared down to meet the anticipated income in order that the JOURNAL would break even.

Dr. Nishijima read a letter from the Hawaii Visitors Bureau, as follows:

Dear Miss McCaslin:

The Hawaii Visitors Bureau is most anxious to extend to the members of the American Medical Association, an invitation to visit Hawaii following their convention which will be held in San Francisco, in June, 1958.

We have helped to promote many similar types of conventions in the islands, and naturally, we wish to have American Medical Association here.

If the Hawaii Medical Association will concur to this invitation we would suggest an invitational letter to go along with ours from the Hawaii Medical Association.

We will be pleased to hear from you regarding this matter at your earliest convenience.

Yours truly,
PHYLLIS MCDONALD
Convention Representative

ACTION:

Dr. Wade moved that the Council recommend to the incoming regime that they consider this very seriously. The motion was passed.

Dr. Wade handed over his resignation which was necessitated by the fact that he is now president of the Kauai County Medical Society and therefore, automatically, a member of the House of Delegates.

Dr. Fronk moved that we accept this resignation. The motion was seconded by Dr. Patterson and passed.

The choice of a successor to Dr. Wade was found to be limited. It was decided to insert Dr. K. Fujii's name on the ballot for the House of Delegates election.

The meeting was adjourned at 10:25 P.M.

MINUTES OF THE MEETING

House of Delegates
Friday, May 3, 1957, at 9:10 A.M.
Parish House

Dr. Webster Boyden, presiding, and Drs. Henry Yuen, Archie Orenstein, J. A. Mitchel, Robert Bailey, Grover Batten, Herbert Chinn, Andrew Morgan, William H. Stevens, Roy Tanoue, Morton Berk, Leabert Fernandez, Takeo Fujii, William H. Gulledge, Clarence E. Fronk, Edmund Lee, O. D. Pinkerton, Harold M. Sexton, Thomas Bennett, M. H. Mack, George Mills, James W. Cherry, Albert Ishii, Leon E. Mermod, Keith Kuhlman, Peter Kim, J. Alfred Burden, F. H. Tong, Edmund Tompkins, and Mr. Richard Kennedy.

The minutes of the December 4, 1957, meeting were approved.

The following alternates were substituted for absent delegates: Dr. Bennett for Dr. Holmes, Dr. Cherry for Dr. James Wong, and Dr. Mermod for Dr. Wilkinson.

COUNCIL RECOMMENDATIONS

The action of the Council authorizing the payment of its members' meeting expenses was approved.

PHYSICIANS' AID

It was voted that the president appoint a committee to look into an indigent physicians' aid program and determine how to finance the plan, and present these recommendations at the next meeting.

RESOLUTIONS PRESENTED AT AMA MEETING

DR. ARNOLD discussed a resolution he would like to present at the next AMA meeting which reads:

"WHEREAS, the principle of the closed shop or union shop, whereby a man is forced to belong to an organization in order to earn his living, is believed to be essentially repugnant to the overwhelming majority of American physicians, and

"WHEREAS, a physician must be, by and large, able to work in a hospital in order to earn his living; and

"WHEREAS, a great many American hospitals require applicants for admission to their staffs to belong to the American Medical Association or a constituent association thereof, and

"WHEREAS, the American Medical Association is thereby made an unwilling party to the application of the principle of the closed shop or union shop, now wherefore be it

"*Resolved,* that the House of Delegates of the American Medical Association defines the requirement of medical society membership for applicants for hospital staff privileges as a closed shop or union shop restriction, and be it further

"*Resolved,* that the House of Delegates of the American Medical Association urges upon its component and constituent medical societies and associations, and upon the American Hospital Association, and upon individual hospitals, a course of action calculated to eliminate the use of the closed shop or union shop principle in relation to the practice of medicine in hospitals."

It was voted that the proposed resolution be presented at the next AMA meeting.

JOINT COMMITTEES

DR. BOYDEN brought up the question of joint committees and explained that there are several committees appointed by both the county president and the Association president.

It was voted that the incoming president appoint a committee to study joint committees and make recommendations.

NEXT ANNUAL MEETING

It was voted that the annual meeting for 1958 be set for the first three days in May.

POST-CONVENTION

It was voted that an AMA post-convention meeting be planned on a territorial level to give it more prestige and that a committee be appointed by the incoming president to take care of the various functions, to include an aloha committee as well as a scientific committee.

BYLAWS

CHAPTER III, SECTION 3, PART *B* NOW READS—

President-Elect. The President-Elect shall be ex officio a Vice-President, and shall act as President in the absence of the President during the President's term of office. He shall be a voting

member of the House of Delegates, of the Council, and of every committee.

It is proposed to insert "ex officio" in the last sentence, changing it to read—He shall be ex officio a voting member of the House of Delegates, of the Council, and of every committee.

This change is proposed to make the wording of the officers' duties uniform.

CHAPTER V, SECTION 2, PART *D* NOW READS—

The officers of the Association shall be ex officio the officers of the Council.

It is proposed to insert the words "excluding all Vice-Presidents with the exception of the President-Elect," changing it to read, "The officers of the Association, excluding all Vice-Presidents with the exception of the President-Elect, shall be ex officio the officers of the Council."

This change is proposed to conform with the actual practice and the intent of the bylaws.

CHAPTER VIII, SECTION 1.

This section now lists 10 committees (*a* through *j*) which must be included in the committees of the Association. They are (*a*) Scientific Program, (*b*) Legislative, (*c*) Meeting Arrangements, (*d*) Cancer, (*e*) Diabetes, (*f*) Health Education, (*g*) Postgraduate, (*h*) Public Service, (*i*) Nominating, and (*j*) Industrial Relations Committee.

It is proposed to add a section (*k*) which shall read "and any other committee the President deems necessary."

This change is to accommodate such new committees as the Mental Health Committee and the proposed Federal Medical Services Committee.

CHAPTER IX, SECTION 1 NOW READS—

Annual dues shall be $25.00 per regular member per year to be collected from each component society.

Section 4 now reads—

The list of members furnished by the component societies at the annual meeting shall constitute the basis of assessment of dues against the component society. Only those members excused from payment of all dues to their component society may be excused from payment of dues to the Association.

It is proposed to change Section 1 to read—

"Annual dues shall be $25.00 per regular member per year to be remitted by each component society as collected and shall be prorated on a quarterly basis."

It is proposed to eliminate Section 4 and add the last sentence, "Only those members excused from payment of all dues to their component society may be excused from payment of dues," to the end of Section 1.

This proposed change will enable the Association to keep an accurate record of its members, will permit members joining late in the year to pay dues for only that part of the year for which they are a member, and will eliminate each county's having to pay dues for members who do not remit to them.

The proposed changes in the bylaws which had been circulated were accepted.

ANNUAL REPORTS

Radium Committee

DR. MCCORRISTON said that he was not the chairman of the Radium Committee, but the chairman was out of town.

All the members agreed that it was the best policy to keep all the radium on Oahu and that it should be given out on a first come, first served basis.

It was voted that we accept the recommendations as outlined. Dr. Stevens seconded the motion and it was passed.

Criteria for Distinguished Service Awards

The recommendation of the committee formed to determine the criteria for making distinguished service awards was accepted.

Reference Committee System for House of Delegates

The recommendations made by Dr. Izumi were adopted.

Treasurer's Report

DR. PANG gave the treasurer's report. He advised it had been approved by the Council the previous night and asked for the pleasure of the delegates.

It was voted that $500.00 be included in the budget for use by the Health Education Committee, and that an additional $300.00 be given to Miss Paty, making a total appropriation of $800.00.

Hawaii Medical Journal

It was voted that Dr. Arnold be allowed to use his own judgment about reducing Journal costs.

DR. ARNOLD said this did not settle the county society reports and asked if they could get reports pared down to the bone and asked if the counties would object to that.

DR. BOYDEN said the counties would accept that.

* * *

It was moved, seconded, and passed that the following committee reports be accepted as submitted and put on file.

Woman's Auxiliary

DR. FRONK said he did not feel the doctors were using the Woman's Auxiliary to their fullest extent.

DR. STEVENS and DR. BERK said they were.

Federal Medical Services Committee

It was voted that the Federal Medical Services Committee be empowered to make the decisions for any negotiations and fees with the federal government, after full consultation with the committee of the County Medical Society, and that the Committee be a rotating Committee with at least one-third of the members remaining on the Committee each year.

It was voted that the Hawaii Medical Association go on record as agreeing with the present Medicare contract until March, 1958, with the stipulation that certain parts were not right.

Mental Health Committee

DR. STEVENS spoke for the chairman of the Mental Health Committee and pointed out that most of the mental health patients are in tax supported institutions and this is a divergent pattern to the Medical Association's thinking on patients under medical care. That the committee chose him to ask the members' support for the addition to Queen's which would establish a new treatment center for the mentally ill.

It was voted that the recommendations made by the Mental Health Committee be accepted.

Public Service Committee

It was voted that the Code of Cooperation proposal that had been prepared by the Public Service Committee be approved in principle.

ANNUAL REPORTS

It was voted that the annual reports be accepted and put on file.

* * *

DR. BURDEN moved that the House of Delegates go on record as approving the present relationship of doctors and HMSA. DR. CHERRY seconded the motion and it was passed.

ELECTION OF OFFICERS

PRESIDENT-ELECT—William N. Bergin
TREASURER—Edward F. Cushnie
COUNCILORS—Clarence M. Burgess, Frank C. Spencer, Kenneth K. Fujii (to succeed Dr. Burt O. Wade, whose resignation was accepted)
DELEGATE—Harry L. Arnold, Jr.
ALTERNATE DELEGATE—Samuel L. Yee

The meeting was adjourned at 12:30 P.M.

SATORU NISHIJIMA, M.D.
Secretary

SPECIAL REPORTS

COMMITTEE ON DISTINGUISHED SERVICE AWARDS
Clarence E. Frank, M.D., Chairman

This ad hoc committee was formed to outline criteria for awarding distinguished service certificates. A meeting was held on March 15 at which the following doc-

tors were present: Fronk, chairman, Gaspar, Hartwell, Ito, and Arnold, Jr.

It was the consensus of the committee that there should be no hard and fast rules laid down but, in general, the following was proposed as a guide only:

1. Candidate should be living. No posthumous awards should be made.
2. Candidate should be at least fifty years of age.
3. Candidate should be a permanent resident of the Territory.
4. Candidate should have rendered service to both the medical profession and the community beyond the call of study of his work or profession.
5. Nominations may be made by individuals or by county societies.
6. The Council should be empowered to make one or more awards whenever candidates are presented. However, it is not expected that a suitable candidate will be presented each year. In fact, it is doubtful that thse awards should be made oftener than once every five to ten years, but the committee did not feel it wise to specify a certain date for awards to be made. It will be necessary, however, to have the names of possible candidates filed at least three months in advance of the Annual Meeting.

REFERENCE COMMITTEES FOR THE HMA HOUSE OF DELEGATES

Homer Izumi, M.D.

The "Reference Committee System" utilizes members of the House of Delegates, appointed (by the Speaker of the House) *prior* to *each* session to various reference committees designated by the bylaws. (See Constitution and Bylaws.) Thus, the vast amount of work of the House is subdivided amongst its members and more efficiently and expeditiously effected.

* * *

Under HMA's present arrangement no provision is made for the officers such as Speaker and Vice-Speaker of the House and the Board of Trustees. However, I could suggest that if it were to be tried temporarily, HMA's President could serve in the capacity of the Speaker and the Council could serve in the capacity of the Board of Trustees.

* * *

There are at present fifteen reference committees of the AMA's House of Delegates. The description and duties of these committees are found in AMA's bylaws, pages 39, 40, and 41, Chapter XII, Section 4. In the left column below they are listed and in the right column are my suggestions for incorporating these committees into a group of five committees:

AMA REFERENCE COMMITTEES	SUGGESTED COMBINATION & NAME FOR HMA
1. Amendment to Constitution & Bylaws 2. Rules and order of Business 3. Credentials	1. Parliamentary Committee
4. Hygiene, Public Health & Industrial Health 5. Medical Education and Hospitals	2. Hygiene, Public Health, and Industrial Medicine
6. Insurance and Medical Service 7. Medical Military Affairs	3. Insurance and Medical Service
8. Legislation and Public Relations 9. Executive Session	4. Legislation and Public Relations
10. Miscellaneous Business 11. Board of Trustees and Secretary, reports of 12. Reports of Officers	5. Miscellaneous Business
13. Sections & Section Work	Probably unnecessary
14. Tellers 15. Sergeants at Arms	Can be appointed from alternate group of delegates

The above suggested streamlining of the committees would be necessary due to the limited number of members of the HMA House of Delegates (total 20). Were this to remain unchanged, the reference committee could be composed of no more than four members but possibly if other committees are necessary, a three-member committee might be considered. It would furthermore necessitate more activity and responsibility, particularly for neighbor island county societies, to activate its alternate delegates to augment and represent its society in the reference committee sessions. In order that continuity of thought and consistency of program be maintained, it is suggested that the delegates and alternate delegates be selected for periods of somewhere between three and five years.

There would be need for preparation of reports in ample time prior to a scheduled meeting to allow committee members an opportunity to review and deliberate. Additional stenographic, clerical, and multigraphic employees will be necessary during the meeting. I would suggest anticipation of such need. Extra personnel might be filled by employing present employees of Honolulu County's staff and paying them on a separate Territorial basis, during the period of the session. (These employees would have considerable night work to get out reports of reference committees.)

The following expenditures by county societies and the HMA should be anticipated for such additional services as mentioned. Furthermore, while it may seem at the moment unlikely, allowance for travel expenses of delegates, officers, council members to regular and interim meetings should be expected inasmuch as more between-meetings may be anticipated. Such expenses borne by the individual, already willing to give his time, over a period of years, could make the duties an unpopular responsibility.

The advanatges of such a program in providing a more efficient, expeditious method of operation is evident in that most large county and state associations have similar adaptations of this system. It makes the duty of the delegate more meaningful, and the knowledge of the objectives and problems of the Association more widely disseminated to the membership. I personally believe some such adaptation could improve the overall operations of the HMA. However, the entire matter should be given further thought, and its wholehearted support by the component societies should be assured before it is attempted on even a trial basis.

REPORT OF THE HAWAII MEDICAL JOURNAL

Harry L. Arnold, Jr., M.D., Editor

The past year has been a remarkably good one for the JOURNAL, and a highly creditable one for our new Managing Editor, Lee McCaslin. As the following tabulations show, the magazine has been bigger, and has cost us less, than ever.

PAGES AND DOLLARS

	1953-54	1954-55	1955-56	1956-57
Original articles	15	15	16	20
Features	21	25	25	33
Nurses	8	8	8	10
Advertisements	38	42	47	51
TOTAL PAGES	82	90	96	114
Income	$16,200	$17,542	$19,014	$21,127*
Expense	13,600	14,905	16,394	18,454
NET "PROFIT"	$ 2,600	$ 2,637	$ 2,620	$ 2,673

* Accrual basis—not cash, as in the budget.

"Profit" is enclosed in quotation marks because the only production costs charged against the JOURNAL in our bookkeeping system are printing and postage. Actually, the salaries of the Association's office staff should be prorated, partly against the JOURNAL expenses and partly against the Association's business. Moreover, printing costs are now rising sharply.

A readership poll was conducted last fall, and the results were tabulated in the November-December issue. It is planned to repeat this, and we would welcome suggestions for questions to be asked. The results indicated

general approval of the content of the magazine, though it is probable that the returns were heavily weighted in this direction by indifference on the part of dissatisfied readers. The departments *Umi Makahiki I Hala*, Library, Perhaps It's Your Nerves, and Woman's Auxiliary received very low votes, and the advisability of continuing these is doubtful, especially in view of increasing costs.

Some county societies have recently voted not to have their minutes published in the JOURNAL, though no such request has come from any of them, and they continue to submit their minutes regularly. This portion of the JOURNAL was "usually read" by 108 of the 139 doctors replying to the readership poll, and serves as a permanent record of the principal activities of the county societies. Members have no other way of knowing what other county societies are doing. A decision as to whether to discontinue it or not should perhaps be made by the House of Delegates.

Advertising has been plentiful all year. Local advertising is now being solicited by Mrs. Lilith Jurry, on a part-time, commission basis. Your help as readers, in reminding advertisers at every opportunity that you "saw it in the HAWAII MEDICAL JOURNAL," is earnestly solicited. If you know of local firms who might deal with doctors and do not advertise in the JOURNAL, please call their, or our, attention to this omission. The more advertising pages we can fill, the larger (and we hope, better) your JOURNAL can become.

With the exception of the decision about continuing the four least-read departments, mentioned above, we recommend the continued publication of the JOURNAL, on the same basis as in previous years.

COUNTY SOCIETY REPORTS

SUMMARY OF ACTIVITIES OF THE KAUAI COUNTY MEDICAL SOCIETY

Sam R. Wallis, M.D., Secretary

Eleven meetings were held during 1956, with an average attendance of 75 per cent.

The Treasurer's report shows a balance of $276.28 as of December 31, 1956.

During the year the following presented scientific papers and discussions: Dr. Louisa Howe, Dr. M. De Bakey, Dr. John Felix, Dr. Ivar Larsen, Dr. John Frazer, Dr. Walter Quisenberry, Dr. T. Nishigaya, Dr. Rodney West, Mr. Ralph Beck, and Mr. Joe Veltmann.

Community work done during the year was a continuation of the tuberculosis skin test and program on diabetic survey.

SUMMARY OF ACTIVITIES OF THE HAWAII COUNTY MEDICAL SOCIETY

Kay K. Ota, M.D., Secretary

April 12: Dr. L. O. Underdahl from Mayo Clinic presented "Hypogonadism" with colored slides. Mr. James Carrol gave a brief summary of activities of HMSA.

May 3: Dr. Paul Reznikoff, Professor of Clinical Medicine of Cornell University spoke on "Hematology." Dr. Nils P. Larsen presented observations from his trip to Japan as well as results of work concerning atherogenic substances in animal fats and high sodium salt diet as a possibility in cause of hypertension. Dr. Henry Yuen, councilor to the Territorial Society, gave his report. Dr. T. Oto was selected to serve as councilor for the next three years.

June 2: Dr. Michael De Bakey, Professor of Surgery from Baylor University, presented "Arteriosclerotic Occlusive Diseases of Lower Extremities."

July 5: Dr. Walter Quisenberry from Honolulu presented a report from the National Cancer Society Meeting. A film on early diagnosis and treatment of lung cancer was shown.

August 2: Mr. Yoshito Tanaka, Hawaii County Attorney, presented the county's viewpoint on free choice of doctors for workmen's compensation cases. Dr. Robert Faus, Mr. Yuen, and Mr. Carrol presented status of HMSA in respect to per cent of utilization in the Blue Shield Plan.

October 4: Dr. J. Warren White spoke on "Fractures and Treatment" at the semi-annual meeting in Honokaa. Dr. George Tomoguchi reported on the meeting of Delegates in Honolulu.

December 6: Mr. L. D. Rowlands spoke on "Vocational Rehabilitation Opportunities of the Big Island." Dr. T. Oto gave the high points of meeting of Delegates.

February 20: HMSA were hosts of the meeting with talks by Mr. Ralph Beck, Mr. Albert Yuen, and Mr. Joe Veltmann discussing various aspects of HMSA.

March 23: Dr. Robert Miyamoto presented a report from the polio inoculation committee regarding clinics. Dr. George Tomoguchi was appointed as delegate to Medicare. Dr. Henry Yuen and Dr. Archie Orenstein were appointed delegates to the territorial HMA meeting to be held in May.

SUMMARY OF ACTIVITIES OF THE MAUI COUNTY MEDICAL SOCIETY

Mamoru Tofukuji, M.D., Secretary

Number of regular meetings: 3.

Number of special meetings: 7.

New members elected:

Dr. Charles V. Bergquist, June 21, 1956
Dr. William Iaconetti, August 14, 1956
Dr. Paul Stevens, October 23, 1956

Members transferred:

Dr. F. B. Warshauer
Dr. Charles V. Bergquist

Guest speakers:

1) Dr. S. Nishijima—Review Cases from Maternal & Child Health Committee
2) Dr. Michael De Bakey—Arteriosclerotic Occlusive Diseases of the Lower Extremities
3) Dr. Reichert—Neck & Head Injuries
4) Dr. Robert Faus, Mr. Albert Yuen—HMSA
5) Mrs. Sugino, Mr. J. Lane—Abolishment of Government Physicians
6) Dr. J. Warren White—Fractures
7) Dr. Sam Yee, Dr. John Felix, Dr. Robert Faus—Dependents' Medical Care Plan
8) Dr. David Rytand—Diuretics
9) Dr. Webster Boyden—Presidential Visit

Movies:

1) *Method and Technique in Ultrasonic Therapy*—Dr. Fleming

2) *Thorazine*—Smith, Kline and French Laboratories
3) *Bronchiogenic Carcinoma*—Dr. Quisenberry
4) *Use of Dionisil in Bronchography*—Dr. Ferkany

SUMMARY OF ACTIVITIES OF THE HONOLULU COUNTY MEDICAL SOCIETY

Thomas H. Richert, M.D., Secretary

The Honolulu County Medical Society had seven regular meetings during 1956. Four special meetings were called during the year (1) to discuss the relationship between the Hawaii Medical Service Association and the Medical Society, out of which the Medical Care Plans Committee was born; (2) to present the report and recommendations of the Medical Care Plans Committee to the Society; (3) to approve the recommendations of the Fee Adjustment Committee regarding changes in the HMSA Fee Schedule and the new fee schedule for the Dependents' Medical Care Program; and (4) to take action on naming a fiscal agent for the Dependents' Medical Care Program. The annual election meeting of the Society was held December 4, 1956. The annual social, or fun meeting of the year, was an old fashioned family picnic held at the Kapalama Beach Club in October.

Activities approved by the Society were as follows:

1. Approval of alternate directors for HMSA.
2. Approval of HMSA as the fiscal agent for the Dependents' Medical Care Program.
3. Approval of the Society's plan to incorporate.
4. Approval of adoption of the California Relative Value Schedule as the Society's average fee schedule with certain changes.

Postgraduate lectures for 1956 were delivered by Dr. Michael E. De Bakey, Professor of Surgery, Baylor University, May 23 through June 2. Dr. De Bakey's series of eight lectures were well received by all who attended.

OFFICERS' REPORTS

REPORT OF THE SECRETARY

Satoru Nishijima, M.D.

The total membership of the Association as of April 1 in all classes is 541, of which 453 (26 more than last year) are paid regular members. By counties the membership is made up as follows:

	REGULAR	ASSOCIATE	RETIRED	LIFE	MILITARY SERVICE	HONORARY	INACTIVE	TOTAL ALL CLASSES
Hawaii	47	—	—	—	1	3	2	53
Honolulu	367	43	3	15	8	12	—	448
Kauai	12	—	—	—	—	—	—	12
Maui	27	—	—	1	—	—	—	28
TOTAL	453	43	3	16	9	15	2	541

The total number of physicians licensed to practice medicine in the Territory of Hawaii as of March 22, 1957, is 731. Of this number 551 are now residing in the Territory.

As of the end of December, 1956, we had 415 active members of the American Medical Association and 44 associate members.

REPORT OF THE TREASURER

H. Q. Pang, M.D.

The balance sheet of the Hawaii Medical Association as of February 28, 1957, and the related statements of changes in funds for the fiscal year that ended were examined by Mr. Frank R. Hough, C.P.A., and found to be in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

The general fund as of March 1, 1956, was $20,524.87, which includes cash on deposit in savings and loan associations, cash on hand in the bank, inventory, liabilities, furniture, etc. There is a net decrease in the general fund for the year ended February 28, 1957, of $742.70, leaving a balance of $19,782.17 in the general fund as of February 28, 1957. This decrease will be offset by the reimbursement from the U.S. Government for some of the expenses incurred in negtoiating the Medicare contract. The Government reimbursed the Association, after the end of the fiscal year, in the amount of $1,896.37, of which $748.80 was turned over to Honolulu County, $45.00 to Hawaii County, $32.90 to Maui County, and $32.90 to Kauai County.

A budget for the income and anticipated expenses for the year 1957-58 has been prepared after careful consideration by Miss Lee McCaslin, secretary, Frank R. Hough, auditor, and myself, and is herewith presented for your approval.

	BUDGET 1956-1957	ACTUAL FIGURE	BUDGET 1957-1958
INCOME			
Dues	$10,675.00	$10,675.00	$11,325.00
Journal Advertising	15,500.00	12,490.84	20,000.00
Journal Subs. and Sales	2,900.00	2,895.70	2,400.00
Annual Meeting			2,500.00
Interest Income	400.00	525.82	525.00
Miscellaneous	170.00	239.93	975.00
	$29,645.00	$26,827.29	$37,725.00
EXPENSES			
AMA Convention	$ 2,145.00	$ 1,200.41	$ 2,500.00
Audit	95.00		235.00
Centennial	21,000.00	16,231.92	
Journal	17,500.00	16,760.02	22,400.00
Library	100.00	100.00	100.00
Miscellaneous	350.00	1,035.91	850.00
Postage	325.00	266.81	275.00
Rental	1,908.00	1,903.86	1,850.00
Salaries	9,600.00	9,759.16	8,700.00
Supplies	300.00	340.35	350.00
Furniture	125.00	50.00	50.00
Taxes	200.00	235.71	315.00
Telephone & Telegraph	300.00	607.26	600.00
Travel	187.00	1,531.83	1,055.00
	$54,125.00	$50,023.24	$39,280.00
Health Education Committee	$800.00	$443.22	*$800.00

* * *

The following recommendations made by Miss McCaslin and myself will be carried out: A new bookkeeping system will be installed within the next thirty days by our auditor, which will reveal more exact information in respect to expenses and will promote a better insight into the operation of the JOURNAL. Cash receipts will be systematically accounted for and susceptible to audit. Savings and loan accounts in excess of the insured amount ($10,000.00) will have $2,500.00 transferred to another institution offering similar interest rates.

The 1956 Centennial Meeting activities resulted in a net income of $5,015.55 after payment of all related expenses. However, gross receipts in connection with the Centennial meeting were not susceptible of audit due to the procedures used in cash handling and recording.

It is recommended that Mr. Frank R. Hough be retained as our auditor since his advice and service have been most satisfactory and his attitude most cooperative.

Serving as your treasurer for two years was indeed an experience and a pleasure and I wish to thank personally Miss McCaslin and her staff for their invaluable cooperation.

COMMITTEE REPORTS

REPORT OF THE AMERICAN MEDICAL EDUCATION FOUNDATION COMMITTEE

Min Hin Li, M.D., Chairman

As the fiscal year of the AMEF ends on December 31, 1956, I am glad to announce that Hawaii had made

* House of Delegates' Resolution (see page 654).

contributions through the AMEF, and also direct to the different state and private medical schools, of a sum total of $10,429.99.

* * *

I still recommend that meticulous care should be given in designating a contribution to the medical schools and not to all the departments of any universities.

* * *

I am glad to announce that Hawaii's doctors gave more than those of Alaska, Arkansas, Idaho, Maine, Montana, Nevada, New Mexico, North Dakota, Oklahoma, Puerto Rico, South Dakota, Vermont, or Wyoming.

REPORT OF THE BOARD OF MANAGEMENT MABEL L. SMYTH MEMORIAL BUILDING

P. H. Liljestrand, M.D., Chairman

Members of the Board of Management for 1956 were: representing the Hawaii Medical Association, Dr. V. C. Waite, Dr. P. H. Liljestrand, and Dr. Leon Mermod as alternate; representing the Nurses' Association, Territory of Hawaii, Mrs. Patience Martalon, Mrs. Myrtle Schattenburg; representing The Queen's Hospital, Mr. A. L. Y. Ward. There were seven regular meetings and three special meetings during the year. Several important steps have been taken in 1956.

1. An amendment to the original agreement between The Queen's Hospital, the Nurses' Association, Territory of Hawaii, and the Hawaii Medical Association was approved. This gives the Board of Management of the Mabel Smyth Building the authority to select the custodian of all rental fees and other monies collected by them. The books are now in the Mabel Smyth office and the director collects the rents. Prior to this everything had to be handled through the Treasurer of The Queen's Hospital, which is the Hawaiian Trust Company.
2. We are a little nearer to solving the problem of space for our tenants. It is the Board's understanding that The Queen's Hospital is willing to help the Library pay for its building when they can settle on the location.
3. We have purchased a master plan from an architect, Lockwood Frost, for the refurbishing of the lounge and lanai. The work on this project has already begun and we hope to complete it in 1957.

* * *

A summary of activities and income from rentals for 1956 follows.

SPACE	TIMES USED	NUMBER PRESENT	TIMES CHARGED	INCOME
Auditorium	126	12,005	32	$1,404.50
Lounge	193	2,377	21	235.00
Lanai	173	5,402	19	126.00
Board Room	16*	94	3	38.00
Stage Room	28	141	----	----------
		20,019		$1,803.50

* January only.

OFFICE RENTALS	PER MONTH	ANNUAL
Honolulu County Medical Society	$360.00	$ 4,320.00
Hawaii Medical Association	154.00	1,848.00
Nurses' & Physicians' Exchange	150.00	1,800.00
Board for the Licensing of Nurses	75.00	900.00
Nurses' Association, Territory of Hawaii	75.00	900.00
Nurses' Assn. District of Oahu desk space	25.00	300.00
	$839.00	$10,068.00

Nurses' & Physicians' Exchange—24 hour service every day
Other offices used daily except Sunday
Honolulu County Medical Society payment includes:

$100.00 for the Library
125.00 (Board Room) for Bureau of Medical Economics
135.00 for the Society's office
$360.00

Rental price of office includes free use of the auditorium, lounge, lanai, the Board Room when it is available, and all equipment.

REPORT OF CANCER COMMITTEE

I. L. Tilden, M.D., Chairman

The Cancer Committee held one meeting during the year, which was largely devoted to a discussion of tumor registries in hospitals. As announced previously, the pathologists in the Territory consented to report all malignant neoplasms studied in their laboratories as to age, sex, race, diagnosis and site starting January 1, 1955. Such reports have been received from all hospitals with the exception of The Queen's Hospital and Children's Hospital.

The committee also approved the establishment of tumor registries by the various hospitals, which would provide more complete data on all cancer cases coming to the hospital, including a mechanism for follow-up reports from attending physicians. (Such a registry was started at Kuakini Hospital on January 1, 1957, using forms provided by the American College of Surgeons. The other hospitals in Honolulu, including Tripler, have approved the project at least in principle.)

The pamphlet on cancer detection prepared by the American Cancer Society was sent to all physicians in the Territory, and the history and examination form approved at the Delegates' meeting of a year ago will soon be mailed to physicians with a covering letter.

REPORT FOR THE CHRONIC ILLNESS COMMITTEE

George H. Mills, M.D., Chairman

There were no meetings of the Chronic Illness Committee held in 1956. Some doubt was raised by members of this committee as to the exact function and feasibility of continuing this group. A long range study of the resources in the community for the care of the chronically ill had been stopped because of the length of time it would take to complete it and the cost.

At this House of Delegates meeting, a suggestion to dissolve the committee was made. This was not accepted and a unanimous vote was received instead to continue the organization on a consulting basis to the Health Department or any other group.

REPORT OF THE DIABETES COMMITTEE

Teru Togasaki, M.D., Chairman

Diabetes Detection Drive for Kauai and Oahu, November 11-17, 1956.

KAUAI	
Method used	Tes-Tape
Number tested	4,972
Positives	303
Old diabetics	44
Newly discovered diabetics	0
OAHU	
Method used	DREYPAK
Number of tests distributed	19,000
Returned for testing	4,424
Positives	125
Old diabetics	19
Newly discovered diabetics	20

Finances came from the McInerny Foundation, $402.16, and two families who donated $75.00 and $25.00 respectively to the Medical Society.

Distribution of the dreypaks was through the Hawaii Retail Druggists Association, industrial nurses, and the public health nurses, as follows:

	DISTRIBUTED	RETURNED FOR TESTING
Retail druggists	11,000	2,843
Industry	4,000	870
Public health nurses	4,000	529

REPORT OF EMERGENCY MEDICAL SERVICE COMMITTEE

Robert B. Faus, M.D., Chairman

Your Emergency Medical Committee met twice to reassign physicians to hospitals for emergency duty and to inspect storage areas for medical supplies.

Civil Defense now has on hand, in safe storage, four mobile hospital units of two hundred bed capacity. There is the equivalent of thirty 1000-casualty units, valued at $27,000 each, stored in coast defense ammunition storage tunnels in Diamond Head Crater.

Blood Bank is in charge of all emergency whole blood, blood substitutes and IV solutions with donor and administration sets enough to cope with a five-day period of emergency operations.

The American College of Surgery Trauma Committee under Dr. J. Warren White is cooperating in getting hospital plans for mass casualties established and operable.

During the past year the following officers have reported for active duty:

Douglas B. Bell
Richard C. H. Hitchen
Edgar W. King, Jr.
Bennett M. K. Lau
James T. Leong
Masao Nakandakari
Wallace Y. Nishikawa
Cecil A. Saunders, Jr.

Released from active duty and returning to civilian life were the following doctors:

Alfred Y. T. Ching
Kenneth E. Ho
Frederick M. K. Lam
Pritchard T. C. Lam
Richard S. F. Lam
William L. Morgan, Jr.
Herbert G. Pang

REPORT OF THE FEDERAL MEDICAL SERVICES COMMITTEE

O. D. Pinkerton, M.D., Chairman

Members of this committee are Drs. O. D. Pinkerton, Grover Batten, John M. Felix, Ivar Larsen, C. C. McCorriston, William Goodhue (Kauai), and J. Alfred Burden (Maui). No member from Hawaii has as yet been appointed.

The committee has met four times and its record has consisted mainly of adjudicating certain Medicare claims. In addition we have requested a sixty-day extension of the present Veterans' Home Town Care Plan contract. It is hoped that we will be able to present to the Veterans' Administration a complete fee schedule based on the Medicare and Relative Value schedules.

The American Medical Association has formed a task force on Medicare. In their first bulletin they listed the tentative Army schedule for renegotiating Medicare contracts in 1958. This schedule starts in January and continues through November, 1958. Contracts are to be renegotiated at the rate of five a month. Hawaii is scheduled for renegotiation in March of 1958.

Medicare contracts state that negotiations must be opened 60 days prior to their expiration date. The Hawaii Medical Association has already written the Army and gotten an extension to the first part of May and it is the considered opinion of this committee that the Hawaii Medical Association should agree to the extension of the present contract, but that when such agreement is transmitted to the Army they should be advised that this agreement is given with the understanding that we feel that some of the fees, and particularly those in the obstetrical section, are inequitable and that we do not wish to continue with these inequitable fees until such time as a new contract is negotiated in 1958. In the meantime, the committee would like to hear from any group that feels its fees are not in line.

It is suggested that on claims where the doctor requests a fee over and above the stated amount, very specific and carefully worded reasons should be given in justification of this request. Also it is most important that all procedures be coded properly before the claims are sent to the fiscal agent. The omission of code numbers leads to misunderstandings, and subsequent rechecks with the physician himself or office staff often are necessary for clarification.

REPORT OF THE HEALTH EDUCATION COMMITTEE

Katherine J. Edgar, M.D., Chairman

Following are titles and the names of participants for TV programs for the past year arranged by the Health Education Committee:

June:	Care of the Newborn Baby—	Dr. H. E. Bowles, Dr. Edw. C. W. Lum, and Mrs. Helen D. Menezes.
July:	Tuberculosis in Hawaii Today—	Dr. Paul Gebauer, Dr. Chew Mung Lum, Dr. Robert H. Marks, and Dr. Kyuro Okazaki.
August:	Ulcers and Cancer of the Stomach—	Dr. Raymond deHay, Dr. L. Claggett Beck, Dr. Richard K. C. Chang, Dr. Randal Nishijima, and Dr. John M. Felix.
September:	Change of Life (repeated by popular request. First shown in March, 1956)—	Dr. K. S. Tom, Dr. Robert C. H. Chung, Dr. Charlotte M. Florine, and Dr. Dorothy S. Natsui, with assistance of Kailua Community Players: Mrs. Georgianne Johnson, George M. Robertson, and Alvin Arnold.
November:	What is your Blood Pressure?—	Dr. Bernard Fong, Dr. John I. Reppun, Dr. K. Kuramoto, and Dr. Yoshi Takagi.
December:	My Aching Back—	Dr. J. Warren White, Dr. B. Allen Richardson, Dr. Sydney Fujita, and Dr. Thomas Bennett.
January, 1957:	"Terrible Two's and Trusting Three's"—	A film about problems of young children, with introduction by Dr. Teruo Yoshina.
February:	Headaches—	Dr. Robert B. Faus, Dr. John J. Lowrey, Dr. Herbert G. Pang, and Dr. Tadao Hata.
March:	"Even For One"—	A new TV film produced by the AMA designed to show the "human" side of a doctor's practice. Introduction by Dr. Toru Nishigaya.
April:	The Vanishing Waistline—	Dr. Dean M. Walker, Dr. Edward T. Matsuoka, Dr. Raymond Yap, and Dr. Clifford Druecker.
May:	*"Problems of the Mind in Later Life"—	A documentary film report from the 1956 "Merrell Symposium on Constructive Medicine in Aging."
June:	Arthritis—	Dr. Andrew Ivy, Dr. I. Nadamoto, Dr. Warren Wong, and Dr. George Henry.

Membership on the committee has been as follows: Katherine J. Edgar, Chairman; Grover Batten, Herbert Chinn, S. R. Horio, Andrew Ivy, Masato Mitsuda, Richard Moore, and Randal Nishijima; plus Jeanne Paty, health educator and technical assistant for programs; and Clarence Chun and James Washburn, KONA program directors.

The budget appropriated was used for newspaper advertising preceding programs because publicity otherwise had proved unreliable. In addition it was the wish of the committee to allot $300 to Jeanne Paty for services rendered during the past three years. Without the consistent assistance of Miss Paty and the KONA program directors (particularly Clarence Chun) the programs would have been impossible.

During the past year postcard questionnaires were circulated to the Honolulu County membership in an effort to learn whether this kind of health education seemed worth while. Forty per cent replied, of which 145 considered the program "worth while" and 7, "not worth while." There are a considerable number of members who are willing to participate in prgorams, many for the second time. Therefore, the committee is willing to con-

* The film "Human Heredity" was substituted.

tinue, though it is desirable to have turnover of committee membership as well as continuity.

Subjects for programs have been selected on the basis of interest by the lay public. Therefore, certain subjects have been rejected because, though important, only a relatively small segment of the public is concerned. Station KONA estimates that the audience numbers 60- to 70,000 at the times the Association has been given public service time.

MENTAL HEALTH COMMITTEE

Pershing Lo, M.D., Chairman

The Mental Health Committee of the Hawaii Medical Association was formed in October, 1956, with the following members: Drs. Pershing S. Lo, Y. T. Wong, Robert Kimmich, James Cherry, Duke Cho Choy, Elmer Johnson, Kenneth Rusch, and John Devereux.

The need for a mental health committee in the Medical Association is quite great. There has been an increasing awareness and interest in mental illness, its treatment and prevention. It is the committee's contention that the treatment of mental illness should always remain a medical responsibility. Unfortunately, the medical profession has been somewhat slow in taking up the challenge and it can be said that various non-medical organizations have been most active in the mental health field. It is therefore imperative that the medical profession become aware of the various mental health activities in the community and take the leadership in planning for mental health problems.

Meetings have been held monthly since the formation of the committee and some of the topics discussed are listed below:

1. Discussion of the general problem of the relationship of psychiatry to the rest of the medical profession.
2. Recognition of the need and encouragement of allocation of psychiatric beds in a general hospital.
3. Encouragement of coverage for psychiatric treatment in voluntary health insurance plans.
4. It was felt that the Medical Association should go on record as supporting the request of the Territorial Hospital for more funds to bring the hospital up to standards.
5. In terms of community health activities, this committee also feels that the Medical Association should go on record as favoring the integration of all mental health services in one department of government.

I feel that this committee should be continued in existence for the purpose of keeping the HMA abreast with developments in the mental health field and also to allow the HMA to assume some leadership in planning for the mental health needs of the community.

REPORT OF THE POSTGRADUATE COMMITTEE

A. L. Vasconcellos, M.D., Chairman

The committee selected Dr. James L. Wilson, Chief, Department of Pediatrics, University of Michigan, and Dr. James L. Dennis, former general practitioner and Associate Professor of Pediatrics at Baylor University and present Medical Director of the Children's Hospital of the East Bay, Oakland, California, to conduct the 1957 series from May 2 to 18.

The committee offers the following recommendations:

1. It would facilitate better planning were the new chairman and committee appointed immediately to plan the subsequent series, but that the old committee be retained until after the current postgraduate series in order that the program could be pursued to its entirety rather than change in the middle of said planning.
2. Immediate meetings to decide the field of medicine and make initial contacts for subsequent years.
3. At least one carry-over member to continue on the new Postgraduate Committee, possibly as chairman of that committee.
4. Consideration of a second speaker with financial assistance through specialty societies, Board of Health, and Community Health organizations.
5. It has been suggested that for subsequent postgraduate lectures perhaps consideration might be made of an M.D. in the field of Medical-Legal Medicine.

REPORT OF THE PUBLIC SERVICE COMMITTEE

Ellsworth B. Harris, M.D., Chairman

The Public Service Committee, composed of Drs. M. Hasegawa, C. T. Druecker, A. L. Vasconcellos, W. A. Myers, and E. B. Harris, met periodically throughout this year.

Last year, at a public relations dinner for representatives of the press, radio and television, a joint committee was formed, headed by Mr. Robert Krauss, to establish a mutual code of cooperation.

A committee has been formed, of which the Public Service Chairman is a member, for the establishment of better relations between physicians and lawyers and the resolution of many pressing medical-legal problems.

Members of the Public Service Committee spent time in an attempt to analyze a contemplated project for the physical evaluation of grade school children. It was their opinion that, in view of the many ramifications and implications of this entire project, further study will be necessary prior to any final recommendation.

REPORT OF THE SCIENTIFIC PROGRAM COMMITTEE

William John Holmes, M.D., Chairman

It was the committee's feeling that panel discussions on subjects of general interest were of more value than "free papers." Accordingly, the committee arranged for the following panel discussions:

1. Jaundice
 Moderator: Dr. S. R. Wallis
 Panelists: Drs. James Wilson, Burt O. Wade, Harold Civin, Roy Tanoue, C. S. Brown
2. Management of Severe Multiple Injuries and Mass Casualties
 Moderator: Col. Warner F. Bowers
 Panelists: Drs. Ralph B. Cloward, Robert G. Johnston, Robert B. Faus, B. Allen Richardson, Herbert Chinn
3. Pre and Postoperative Sedation
 Moderator: Dr. Paul Gebauer
 Panelists: Drs. Clifford K. W. Chock, W. S. You, G. W. Bachmann, Jr., Lester Yee, Shoyei Yamauchi
4. Acute Pediatric Problems
 Moderator: Dr. Duke Choy
 Panelists: Drs. James Dennis, Clifford Kobayashi, Raid B. Chappell, F. D. Nance

In addition to the foregoing, the committee also arranged for two popular AMA films, "The Medical Witness," and "The Case of the Doubting Doctor," during the annual meeting.

REPORT OF THE WOMAN'S AUXILIARY

The most significant achievement of the Woman's Auxiliary in 1956-57 is that on February 7, 1957, Kauai established a component unit of this organization, making 100 per cent for the four island counties. Kauai auxiliary-ites plunged immediately into plans for entertaining doctors' wives at the annual territorial convention.

The Auxiliary is pleased to report a current membership of 287, 126 over a year ago.

Since last year's annual meeting there have been three executive board meetings, two meetings with the Advisory Committee and one conference between Dr. Fronk, chairman of that committee, and Mrs. Tompkins. The Advisory Committee recommended that the Woman's Auxiliary:

1. Continue promoting Today's Health subscriptions.
2. Work on the Mental Health project, at the county level.
3. Solicit AMEF contributions, only among the medical and allied professions.
4. Include in "In Memoriam—Doctors of Hawaii"
 a. Doctors of the armed forces if they establish residence in Hawaii.
 b. Questionable biographies only after conference with the Advisory Committee.
5. Continue "Register and Vote" campaigns, at county level.

Conventions in Honolulu did not end with the wonderful centennial celebration. In June there was a Dermatologists' convention and in February, 1957, the Allergists met there. Both times groups of auxiliary members organized, entertained, and assisted.

Lest it be thought that these affairs preclude good fellowship activities, a family skating party was held in May, and in October the Medical Society invited the Auxiliary to a family picnic which was then planned jointly.

ADVISORY COMMITTEES

REPORT OF THE ADVISORY COMMITTEE TO THE BUREAU OF CRIPPLED CHILDREN

I. J. Larsen, M.D., Chairman

The Advisory Committee to The Bureau of Crippled Children had its annual meeting on January 28, 1957, at the Mable Smyth Building and reviewed the following activities of the Bureau.

Hearing Conservation Program

Prolonged discussion of the Hearing Conservation Program was precipitated by a letter from the president of the Honolulu County Medical Society challenging the Bureau of Crippled Children's policy of referral of children with hearing defects requiring T & A's to Board qualified otolaryngologists for removal of their tonsils.

The committee unanimously approved the program as it is allowing the fees for payment of T & A's to certified otolaryngologists only, for the remainder of this fiscal year, and recommended that the president of the Honolulu County Medical Society appoint a committee to assist the Bureau of Crippled Children in working out a plan for the Conservation of Hearing Program for the 1957-1958 fiscal year.

Pre-operative Fee Schedule

At the suggestion of this committee last year, a fee of ten dollars was established as the adequate fee for preoperative examinations authorized by the Bureau of Crippled Children and that this fee was to include urinalysis and hemoglobin count. The results of this recommendation, apparently, were very gratifying and so no further action was necessary.

Meeting on the Neighbor Islands

The suggestion of having the Bureau of Crippled Children committee meetings on neighbor islands was felt inadvisable by this committee in view of the expense involved.

Surgical Eye Program

It was recommended by the committee that refraction should not be part of the three-month aftercare of surgical eye cases but should demand an additional fee for services. No further action nor recommendations were made by this committee.

REPORT OF THE ADVISORY COMMITTEE TO THE BUREAU OF MATERNAL AND CHILD HEALTH

Fugate Carty, M.D., Chairman

The committee met during the past year to consider eleven maternal deaths and defined six as due to obstetrical causes. Five of these six were considered preventable deaths after thorough discussion of the material available. In many cases the investigative forms supplied to physicians were incomplete and lacking in essential data. The committee again makes a plea for more cooperation in their effort of investigation of maternal deaths.

The committee again made note that stocking of low titer "O" blood in all island hospitals is an essential, and that study of the advisability of having fibrinogen readily available would be made in conjunction with the Blood Bank.

It is recommended by the committee that routine cervical and urethral smears be discontinued except in risk cases, and that emphasis be placed on cytological smears on women twenty-five years or older.

The committee regrets to state that its study of infant deaths has not successfully kept pace with that of maternal death studies. The chairman suggests that a co-chairman be appointed (a pediatrician) to organize these cases for presentation to the committee.

REPORT OF THE ADVISORY COMMITTEE TO THE BUREAU OF TUBERCULOSIS

Fred I. Gilbert, Jr., M.D., Chairman

The committee had one meeting, on August 13, 1956, which was called because of cases of active tuberculosis having been found among school teachers. After reviewing this matter the Committee wrote a letter to Mr. Clayton J. Chamberlain, Superintendent of Schools, recommending that the Department of Public Instruction further investigate this problem and consider appointing a medical advisor to their staff.

Mr. Chamberlain replied that they had a committee on recruitment, placement, and adjustment working on a revision of their policies and procedures in that area and that he was asking them to consider the recommendation in connection with this whole problem on teacher health and adjustment.

There has been no further report from the Department of Public Instruction on this matter.

REPORT OF THE ADVISORY COMMITTEE TO THE BUREAU OF VENEREAL DISEASES

Edmund Ing, M.D., Chairman

In August 1956, this committee held a meeting with this agenda:

1. Discussion of the occurrence of infectious syphilis in Honolulu.
2. Treponema pallidum complement fixation tests.
3. Resurvey of large industrial groups at Fort Shafter, etc.
4. Review pre-marital and pre-natal statutes.

The VD Bureau reported that two cases of infectious syphilis have been found within recent months. The committee approved issuing a folder to the physicians of the Territory advising them of the situation and to be alert rather than to be complacent about syphilis.

The VD Bureau described a plan, which was approved by this committee, for serologic study of a group of civilian employees at army posts to get an idea of whether or not any unsuspected latent syphilis may be present here.

REPORT OF THE HEART ADVISORY COMMITTEE

Kikuo Kuramoto, M.D., Chairman

The Heart Advisory Committee had one meeting during the year on December 10, 1956, with the members of the Territorial Department of Health.

The committee approved of the following:

1. The booklet to be published by the Territorial Department of Health called, "How to Feed Your Heart."
2. Project to study obesity among school children.
3. Classes in meal planning and preparation for patients of private physicians by Department of Health.

NO REPORTS

1. Legislative
2. Radium
3. Hawaiian Academy of Science
4. Examining Board for Hansen's Disease

INTER-ISLAND NURSES' BULLETIN

Official Publication of the Nurses' Association, Territory of Hawaii

ROSIE CHANG, *Editor*

DORIS GREGORY, *Associate Editor*
NORA SHIROMA, *Associate Editor*

ANNE CAMARA, *Associate Editor*
MILDRED KIM, *Associate Editor*

OLIVE C. PRIDGEN, *Executive Secretary*



OFFICERS AND COMMITTEE MEMBERS

Standing, left to right: Josephine Basa, Kay Irwin, Betty Sora, Edna Chapman, Practical Advisor; Encarnacion Gerardo, Edith Hinchliffe, and Eunice Sun. Seated, left to right: Lucille Fujimoto, Janet Baker, 2d Vice-President; Alene Humphries, Tsugie Kadota, Treasurer; Nobuko Hayashi, Secretary; Elvie Manley, President; Helen MacPherson, Territorial and Local Board Member, and Josephine Duvauchelle, Board Member.



MEMBERS OF SCHOLARSHIP AND RUMMAGE SALE COMMITTEES

Left to right: Florence Shibano, Rummage Chairman; Alene Humphries, Edith Hinchliffe, Scholarship Chairman; Janice Baker, Josephine Duvauchelle, Edna Chapman, Elvie Manley, and Lucille Fujimoto.



SPECIAL FUND RAISING COMMITTEE FOR CONVENTION

Left to right: Tsugie Kadota, Elvie Manley, Esther Shigeta, Josephine Basa, Edna Chapman, Betty Sora, and Janice Baker.

Featuring
Kauai Nurses

At the annual meeting held in January Mrs. Pauline Johnson was elected president of the Kauai Nurses' Association. Other officers elected were Miss Janet Baker, 2d vice-president; Mrs. Tsugie Kadota, treasurer; and Mrs. Helen MacPherson, Mrs. Edith Oride, and Miss Myrna Campbell, directors. Holdover officers are Miss Thelma Hensley, 1st vice-president; Mrs. Nobuko Hayashi, secretary; and Mrs. Josephine Duvauchelle, director.

Mrs. Johnson named the following as committee chairmen: Miss Elvie Manley, finance; Mrs. Helen MacPherson, program; Mrs. Martha Ohama, arrangements; Mrs. Florence Shibano and Miss Janet Baker, rummage; Mrs. Josephine Duvauchelle, public relations and bulletin; Miss Encarnacion Gerardo, aloha; Miss Elizabeth Middleton, constitution and bylaws; Mrs. Betty Sora, nomination; Mrs. Eunice Sun, membership; Miss Kay Irwin, civil defense; and Miss Edith Hinchliffe and Mrs. Grace Furugen, scholarship.

In May, 1957, the members of the Kauai Nurses' Association heard of the resignation of Mrs. Johnson as president. The Johnson family is leaving Kauai soon and will reside in Arizona. Miss Elvie Manley of the Wilcox Memorial Hospital staff was elected president to succeed Mrs. Johnson.

Two committees that work together very closely are the Rummage Sale and the Scholarship Committees. In 1950 the Kauai Nurses' Association decided to offer to high school graduates nursing scholarships to help alleviate the nursing shortage on Kauai and also to help deserving needy students interested in nursing careers. The Rummage Sale Committee was formed to raise funds for the scholarshiaps and a sale is conducted each year.

The first student to be awarded a scholarship

NURSES' ASSOCIATION
County of Kauai

COMMITTEE CHAIRMEN AND MEMBERS

Civil Defense
Miss Irwin, *Chairman*
Committee on call

Nomination
Mrs. Sora, *Chairman*
Miss Hetrick
Mrs. Ohama
Miss Campbell

Membership
Mrs. Sun, *Chairman*
Mrs. Strite
Miss Kikugawa

Program
Mrs. MacPherson, *Chairman*
Miss Hensley
Miss Humphries
Mrs. Umipeg

Rummage
Mrs. Shibano, *Chairman*
Miss Baker, *Co-Chairman*
Miss Hensley
Miss Fujimoto
Mrs. Law
Miss Chapman

Public Relations & Bulletin
Mrs. Duvauchelle
Miss Nishimitsu
Mrs. Shigeta
Miss Basa

Constitution & Bylaws
Miss Middleton, *Chairman*
Mrs. Hayashi
Mrs. Kawate

Finance
Miss Manley, *Chairman*
Mrs. Kadota
Miss Hensley
Miss Chapman

Arrangement
Mrs. Ohama, *Chairman*
Mrs. Kono
Mrs. Wade
Miss Aragaki

Scholarship
Miss Hinchliffe, *Chairman*
Mrs. Furugen, *Co-Chairman*
Mrs. Duvauchelle
Miss Chapman

Aloha
Miss Gerardo, *Chairman*
Mrs. Michioka
Miss Chapman

was Miss Euphemia Padilla, who has since returned to Kauai to work as a staff nurse at the Wilcox Hospital. She is now on the mainland. In 1953 the Association gave one scholarship. Two were given in 1954, two in 1955, and two in 1956. At the present time we have three students in training centers. The students are chosen on the basis of scholarship, personality, and need. The only obligation the student has to the Association is to return to Kauai upon graduation and work for at least one year. However, if there is no position open, the student is released from this obligation.

Members serving on the Rummage Sale Committee are Mrs. Florence Shibano and Miss Janet Baker, co-chairmen; Miss Thelma Hensley, Miss Lucille Fujimoto, Mrs. Alice Law, and Miss Edna Chapman. Those serving on the Scholarship Committee are Miss Edith Hinchliffe and Mrs. Grace Furugen, co-chairmen, Mrs. Josephine Duvauchelle, and Miss Chapman.



CHARTER MEMBERS
Members and guests at Kauai's 25th Anniversary Banquet on March 14 at the Wilcox Hospital Nurses' Home.

The lure of the island of Hawaii is upon us as convention plans for the Territorial Nurses' Association are being made. To help send our quota of delegates to the convention the Finance Committee has been working overtime to think up money-making projects. Headed by Miss Elvie Manley, committee members Mrs. Tsugie Kadota, Miss Thelma Hensley, and Miss Chapman have planned a White Elephant Sale, a Card Party, and a "project." A second-hand living room clock will be offered as a prize to the person holding the right paste board ticket which is obtained by leaving a donation of twenty-five cents with a member of the Association. Some of the Honolulu members must be eager to see their Kauai friends in Hilo as they participated in our little project.

Editorials

According to the Hawaii Visitors Bureau brochure, the Island of Kauai has many important historical points. Kauai contains the clearest traces of menehunes, the first inhabitants of Hawaii. In Island legends they were noted for performing prodigious feats with amazing speed. On Kauai more than on any other island native Hawaiian culture is closely linked with its Tahitian background. Captain Cook made his first landing on Kauai and was welcomed as a god. The bastion of a century-old Russian fort forms a grim reminder that Russia once reached out for Hawaii. It was on Kauai that the Hawaiian sugar industry had its beginnings. Kauai is the smallest and oldest island of the Hawaiian chain. Its craters and cones have worn away and its fertility, lush foliage and floral growth have caused it to be named the Garden Isle. Deep colorful canyons, expansive golden beaches, winding rivers—the largest in Hawaii—add to the wealth of its scenery.

According to the figures of the Board for Licensing, 67 nurses are registered on Kauai. NATH statistics show 47 nurses are members of the Association. Kauai District Nurses' Association was the first district to offer its students annual scholarships in nursing at Queen's and St. Francis Schools of Nursing. Through these pages you will read of their accomplishments.

President's Message

The past legislative period saw NATH supporting two major items which were accepted by the House of Delegates as the Association's legislative program. This seems to be an appropriate time to summarize our action and mention the results.



LYNNE WIGEN, *President*

The budget passed by this session and signed by Governor King allotted some $4,380,000 to the Territorial Hospital. Forty-six nursing positions were granted; 160 positions were requested. The requested minimum budget was $5,000,000. However, in spite of the disappointing cut in necessary funds, the work of many active committees must not be underestimated. Some ground has been gained in informing the public, as well as the legislature, of the needs.

In this same budget the request of the Department of Health for fifteen nursing positions was answered by five new positions. When it began to be apparent that the request of the Department was not going to be met, there was a separate bill introduced for ten school nurses. However, in spite of much interest from the health committee at a hearing, this bill died in the finance committee. Through the efforts of the Board itself and our Association members, the financial plight of the Board for Licensing was successfully solved by two actions. First, the auditor agreed to allow the Board to withhold its final payment until after legislative steps are taken to correct the problem. This allows the Board to remain functioning. Second, the amount of Board's funds mandated by the legislature for other than Board action was reduced from $13,290 to $6,972. The question of having an independent board was decided when the Governor signed into law SB 704 which now places Board for Licensing funds under the Territorial general fund.

Many other bills came to our attention which demanded action or a statement from NATH. In

the next session of the legislature there will again be items of major interest to nurses. In order to support a successful legislative campaign, it is necessary for everyone to be an active and informed member of the team.

The House of Delegates in September also passed a resolution stating our belief in the need for an adequate and realistic civil defense program. NATH has already taken a first step in this vital matter. Qualified and interested nurses have been trained as instructors and now the second step is being conducted in the 24-hour courses offered in three Honolulu hospitals for all nurses. These are designed to provide our community with a capable and well instructed group of nurses who will be able to give immediate service in the event of an emergency. This program will be expanded to include neighbor islands as soon as they have stimulated enough interest and have enlisted enough nurses who wish to take it.

Although there has been great effort in all other projects, one jarring note in NATH's progress is that in spite of the fact that more nurses are licensed in the Territory than ever before, there has been no increase in NATH membership and in fact we are actually behind the figures in comparison to last year. The dates for the ANA Roll Call have been set for June 24 to 26. We are sending our executive secretary, a common practice in other states since a great deal of the work of the membership drive must be initiated from SNA office. This is another project which will be brought to the neighbor island districts.

Hawaii district nurses will be hostesses at the forthcoming convention. This should be an outstanding event and well worth your attention and interest as well as your active participation.

General Interest

HOW THE 1957 LEGISLATIVE SESSION AFFECTED NATH

Public Health Nursing

The 1957 Legislature granted part of our request for additional nurses. In recognition of the expansion of public health services on Oahu, due to the tremendous increase in population, five additional public health nurses were allowed. These five, the only increase in staff since 1949, will change the Oahu ratio of nurse to population from 9,891 to 9,315. Rural Oahu, in particular, will have more adequate service to schools, more supervision for the increasing numbers of tuberculosis patients discharged on drugs, and more adequate nursing service for maternity, child health, and youngsters with special health problems.

The ten other positions which were requested to increase nuring time in paroachial and public schools throughout the Territory were not allowed. This leaves us with a recognized deficiency in nursing services to the schools on all islands.

This degree of progress in securing better public health nursing services for Oahu was due in considerable measure to the first support given by NATH, the Tuberculosis & Health Association, Oahu Health Council, and many others in the community who understood the problem and expressed their concern to the Legislature.

How the Board for Licensing Fared

To put it simply, the Legislature made amends and satisfactorily adjusted the financial crisis. Act II passed by the 1956 Special Session appropriated $13,290 from the Board's reserve fund to the government workers' pay increase fund. Act II was amended in the regular session by changing the appropriation of $13,290 to $6,972. This amount has been transferred out of the Board's Special Fund. Although there is no reserve left, the basic program of the Board has continued in operation.

The Board lost the services of its very able Executive Secretary, Mrs. Dorothea Spears, on May 31 when she resigned in order to accompany her husband to his new station on the mainland.

SB 704 became a law on June 8. This Act requires the Budget Bureau to study and to exercise more control of all special funds.

Territorial Hospital

In spite of great interest and community support, the Legislature granted only half the budget increase needed by Territorial Hospital. Governor King recommended a total budget of $4,940,881 for the two-year period, including a total number of positions of 475. The Legislature allocated $4,333,378 and a total of 398 positions. This was a great disappointment but definite program improvement will be made with the increases.

Sixty-seven new people can be hired, including 11 Registered Nurses and 36 Psychiatric Aids. Ward coverage will be improved, resulting in better attention to the patients. Convalescent services for patients leaving the hospital will be increased on Oahu, allowing real treatment and rehabilitation activities and consolidation of the hospital's three small follow-up clinics. Earlier discharges and fewer returned patients are expected.

Two new 50-bed wards as well as new maintenance shops are to be constructed.

ROBERT A. KIMMICH, M.D.

JUDITH E. WALLIN, ANA REPRESENTATIVE, NATH CONVENTION

We are delighted to announce that Judith E. Wallin, R.N., assistant executive secretary of ANA administering activities of public health nurses section, will be our guest for the October convention on the island of Hawaii.

Her present professional activities include membership in the National League for Nursing, the Catholic Nurses' Council of the Archdiocese of New York, and New York State Nurses' Association, District No. 13.

Among her past positions she lists: Visiting Nurse, County Nurse, School Nurse, Nursing Bureau, Metropolitan Life Insurance Company, Staff Nurse, Local Supervisor, Local Field Supervisor, Territorial Supervisor, Army Nurse Corps, World War II, and National Organization for Public Health Nursing.

She received her B.S. Degree in Nursing Education from Louisiana State University and her Public Health Certificate from University of Minnesota Graduate School of Nursing, St. Barnabas Hospital, Minneapolis, Minnesota.

ECONOMIC SECURITY

It gives us a great deal of pleasure to be able to announce that your Executive Board, on the recommendation of your Economic Security Committee, has accepted and endorsed a NATH Group Disability Plan wihch will be made available to members. This plan is similar to the Honolulu County Medical Society's Group Disability Plan which has been in effect since 1950. It will offer Loss of Income Disability Protection and, as an optional addition, a Monthly Hospital Indemnity and Surgical Indemnity. The plan is underwritten by the Continental Casualty Company and administered by Brainard & Black, Ltd.

The new NATH Disability Plan will provide monthly indemnities of $100, $150, or $200 a month, plus Accidental Death and Dismemberment Indemnities up to $2,000. In addition there will be a $300 Monthly Hospital Indemnity and a $200 Surgical Expense Indemnity available as an optional benefit. Due to the mass purchasing power of our organization and the economies of mass administration, the cost of this plan is substantially less than any comparable coverage obtainable on an individual basis.

The insurance of an individual member under age 70 cannot be cancelled by the company nor her renewal refused so long as she remains a member of NATH, is actively engaged in nursing, and the plan remains in force. The plan will not require house confinement as do so many individual plans. These are just a few of the many advantages offered by this NATH Disability Plan.

In the NATH Disability Plan we have found a plan of disability benefits that will serve the best interests of the majority of our members, that will attract a high percentage of participation, and that is established on such a sound basis it will prove to be permanent and stable throughout the years to come. The indemnities are attractive without being excessive; the cost is justifiably low by reason of the economies of operation without being too low to fulfill the obligation; the terms and provisions are liberal enough to cover all reasonable contingencies without being so liberal as to provide a basis for abuse. These provisions are based upon more than thirty years of extensive and successful experience in the highly specialized field of insuring professional associations.

An open enrollment period will be set aside for October and November during which all members will be entitled to enroll in the plan *without* showing *evidence of insurability*. provided 50 per cent of the eligible members enroll during this period. Participation on the part of the majority of the membership will make it possible for those members who might ordinarily be unable to obtain protection, due to uninsurability, to take advantage of this plan. Only the cooperation of the membership can make the NATH Group Disability Plan successful.

Brainard & Black, Ltd., the administrator of our plan, will have a booth at the NATH Convention in October and a representative will be available during the convention answering questions and assisting in enrollments.

OLIVE C. PRIDGEN, R.N.

HAWAII STUDENT NURSES' ACTIVITIES

This past year, student nurses took an active part in nursing activities both national and territorial. In September student nurses were asked to participate in the program for the Territorial Nurses' Convention held at the Mabel Smyth Building. A chorus made up of St. Francis School student nurses opened the meeting with a song. The presentation of flags and the Florence Nightingale Pledge was then given by the student nurses.

During November six students attended a business meeting in the Officers Club of the Tripler Army Hospital. Nurses' Association, District of Oahu, asked for student entertainers for a banquet held in December at the Evergreen. Rebecca Quitazol, St. Francis; Jane Iwata, University of Hawaii; and Doris Morinoue, Queen's, were three who performed.

In March the HSNA council chose Lainie Yuen of St. Francis, Joy Segawa of Queen's, and Evelyn Pang Lee of University of Hawaii as the scholarship recipients for the year. Each received $50 to be used toward education. Miss Audrey Lum of St. Francis was elected by the HSNA council to represent Hawaii at the National Student Nurses' Association. She left in February for St. Louis Hospital. The council paid for her expenses to and from the convention site.

A dance was sponsored by the HSNA in May to raise money for next year's scholarships. It was held at the St. Louis Alumni Clubhouse. Eleanor Suzuki of Queen's was the HSNA queen for 1957. Her court consisted of Barbara Young of St. Francis and Linda Lee of University of Hawaii. Queen's School had their Junior and Senior Prom at the Ala Wai Clubhouse and invited the other schools of nursing. University of Hawaii had a pinning ceremony at Hemenway Hall on June 8.

VIRGINIA ALICE JONES, WHO Nursing Consultant

Miss Virginia Alice Jones, Director of School of Nursing, University of Hawaii, has accepted a position as Nursing Consultant for the World Health Organization in Taipei, Formosa, for a six-month period. During this appointment, Miss Jones will be enjoying her second sabbatical leave from the University of Hawaii.



MISS JONES

While in Taipei Miss Jones will review the present plans for the undergraduate program in nursing education at the National Taiwan University and advise the University authorities on future developments. She will also assess the needs of Taiwan for education programs for graduate nurses and make recommendations to the University, other institutions, and international organizations in regard to preparing nurses for responsible positions. Additional duties will include consultant services in nursing education to members of WHO nursing education teams and assisting in the orientation of any WHO nurse who may be appointed during the period of her consultantship.

En route to Formosa, Miss Jones will observe nursing and nursing education in Japan, Korea, and the Philippines. These observations will be helpful to understand better the needs of the nurses who come to Hawaii for additional study.

Miss Jones is well known professionally both on the mainland and in Hawaii. Her mainland experience has been in positions of public health nursing in California and Indiana; Director, Program of Study in Public Health Nursing, Indiana University; and Education Secretary of the National Organization of Public Health Nursing. In 1940 she joined the faculty of the University of Hawaii as Instructor in Public Health Nursing. In 1945 she was granted a four-month leave of absence to serve as an American Red Cross Nursing Consultant for the Philippine Red Cross in Manila. Miss Jones has served on innumerable committees of the community health organizations. Professionally she has held offices such as Past President of The Nurses' Association, Territory of Hawaii, The Hawaii League for Nursing, The Hawaii Public Health Association, and Chairman of Board for Licensing of Nurses, Territory of Hawaii.

Have a wonderful trip, Miss Jones. When you return in February, we will enjoy sharing your experiences as a WHO Nursing Consultant.

THE ATOM REPORTS AGAIN

The instructor-trainee program has been completed and the first class for professional nurses is under way at Leahi, Queen's, and St. Francis. This sixteen-week course on Mass Casualty Care and Territorial Organization is conducted by the nurses and the Territorial Civil Defense officials.

Volunteers from the District of Oahu Nurses' Association and senior students from the nursing schools have participated in uncrating boxes and setting up the 200-emergency-bed hospital now located at Leahi Hospital. The project should be completed by midfall.

Nurses interested in having this program presented on the outside islands may contact Sister M. Laurine, chairman of Civil Defense Committee of NATH, Mabel Smyth Building, Honolulu, for information.



NATH CIVIL DEFENSE COURSE

Approving the course for graduate nurses are: Dr. Leo Bernstein, Alternate Assistant Director, Health and Medical Service, Territorial Civil Defense Agency; Miss Alison MacBride, Member, NATH Civil Defense Committee; Dr. Richard Lee, Assistant Director, Health and Medical Service, Territorial Civil Defense Agency.

Clinical and Technical

NATIONAL TUBERCULOSIS ASSOCIATION ANNUAL MEETING

Your associate editor, Anne Camara, had the opportunity to attend the National Tuberculosis Association Convention in Kansas City, Missouri, from Sunday, May 5, to Friday, May 10, 1957. More than 2,000 visitors from all parts of the mainland and from the territories of Hawaii, Alaska, and Puerto Rico witnessed well-planned sessions in the medical, nursing, and public health areas of tuberculosis and allied fields.

The day prior to the convention a seminar on tuberculosis nursing, sponsored by the Joint Advisory Service on Tuberculosis Nursing of the NLN and NTA, was held at the Muehlebach Hotel for interested nurses. The theme of the entire session was "Better Nursing Care of Patients" and "The Education of Nurses for Tuberculosis Work."

Outstandingly portrayed at the meeting were emphasis on tuberculin testing programs, the problem of tuberculosis and alcoholism, rehabilitation of the tuberculous patient, case finding programs, and the education of patients and families.

This gainful journey offered the writer many avenues of stimulating experiences which she hopes will foster her work in years to come. The meeting provided appreciation and growth in the following:

1. Increased knowledge in numerous areas in tuberculosis—prevention, care, rehabilitation, and education.
2. Increased awareness and understanding of problems associated with case finding; i.e., there are still some mainland areas without chest clinics, public health nursing supervision, social services, and rehabilitation.
3. That nursing in tuberculosis continues to offer dynamic, active, and fascinating challenges for members of this profession.
4. That national trends in tuberculosis are in step with the times as demonstrated by the varied research projects in almost every conceivable topic.
5. That tuberculosis is still a serious world problem and it is far from being eradicated; i.e., a good proportion of patients are not receiving adequate care due to bed shortages and other problems in some mainland cities.

Nursing Education and Nursing Service

REPORT OF THE INSTITUTE ON COMMUNICATIONS

OLGA FROJEN AND CONSTANCE CARMODY

"Words are the music which charm the serpents guarding another's treasures," was the basic theme when Mr. Nelson Prather, Director of Public Relations for Hawaiian Sugar Planters' Association, discussed the *ABC's of Communication* at the EACT Institute on "Keys to Effective Communication" at the Hawaiian Village Long House on May 3. Excerpts from the film *"By Jupiter"* illustrated good and poor ways of employer-employee communications and their beneficial or disastrous consequences. With this background of information and orientation, each of the buzz groups was given six questions for discussion and solution during the afternoon session. A chairman presided and a secretary recorded the answers for each group. After the buzz sessions, the secretaries presented the group questions and answers and there was correlated discussion by the audience and panel members. Because of the highly favorable comments from the audience, we are presenting the group thinking because we feel that BULLETIN readers who were not present would appreciate reading the many positive suggestions to further the "art of developing understanding."

What do we try to achieve in person-to-person communications?

Understanding, persuasion, putting the other person in position to accept or reject our opinion.

What are some of the important benefits of developing a receptive attitude?

Minimizes preconceived opinions, contributes to our reputation of open-mindedness, promotes growth in our understanding of personalities, contributes to appreciation for individual differences, presents a means of learning other person's attitudes and goals, establishes better relations or means of continuing good relations, leads to accomplishment of goal more readily, promotes growth among the workers, increases consideration for feelings and problems of others, and develops virtue of humility.

Define empathy as applied to two-way communications.

It is the ability to place oneself in another person's situation mentally and emotionally without having experienced a similar situation.

What do you lose by having a "tuned out" mind?

Trend of thought, opportunity to participate, knowledge, many good suggestions, understanding, interest, professional time, work satisfaction, perceptio of what is being accomplished, and confidence because of inaccurate information.

Give examples of words or ideas that might mean one thing to one man and something quite different to another.

Perhaps, yes, no, middle age, tomorrow, conservative, aggressive, independent action, and democratic.

What are some of the important differences in people which can make a difference in the way you communicate with them?

Variations in intelligence, interests, predispositions, cultural background, family standards, and sanctions; learning motivation, behavioral differences, sense of values, personality, economic and social positions, group pressures, receptivity, attitude, and education.

What steps should be taken before you communicate with a person?

Identify the problem, have a clear idea of the message to be communicated, develop proper timing, plan a logical sequence of presentation, select an effective method of presentation, possess a sincere belief in the content of the communication, create a climate for participation which will be conductive to acceptance, and present a full discussion of the issue before presenting the message.

What do you do if you seem to have constant trouble getting through to a person?

Endeavor to understand the personality of the other person, remember repetition is essential for the strengthening of changing attitudes, state material in terms of the other person's self-interest, use a positive approach, aim to reach the other person through emotions rather than intellect be objective about individual differences, try different approaches, learn more about the other person (particularly his personality), appoint another person to approach him if there is a personality conflict (poor choice), evaluate ourselves and our techniques, consider the other person as an individual, be a good listener, and aim to have the other person understand your motives.

What do you do if you find a person has consistent trouble getting through to you?

Make yourself available, recognize the value of other people's ideas, use proper timing, and evaluate yourself and your relationship with others.

In giving an order, or any other communication, what emotional factors do you have to take into consideration?

Remember no relationship can rise above the intent of the parties concerned, be aware of non-logical elements (feelings, sentiments, beliefs).

What are some of the important unspoken ways in which we communicate with people?

Through evidence of feelings which display gratitude, pleasure, hope, happiness, loyalty, fear, shame, anger, hostility, guilt, and embarrassment; through facial expressions, evidence of warmth, sincerity, indifference, and enthusiasm; through attitudes, manners, unbroken silences, body position, gestures, inaction, reluctance, and indecision; through body action, body reaction, carriage, poise.

How do you think the attitudes we show affect the acceptance of what we say?

Enthusiasm and self-confidence promote acceptance, defeatist attitude evokes disinterest, positive attitude promotes positive response, negative attitude promotes negative response, and neutral attitude promotes neutral response.

Why is "climate" important in person-to-person communications?

It promotes participation as well as maintains discipline. A climate which leads to acceptance and respect up, down, and across organizational lines has top priority for effective communication.

What can we learn from observing as well as listening to other people?

By observing we note from his attitude and reaction the person's perceptiveness to what we are saying.

Give examples of how we can use unspoken communications to our advantage.

A smile, a wink of the eye, or a nod of the head to indicate approval.

How can we equip ourselves to deal with emotional blocks to effective communication?

Know the individual better, state material in terms of their self-interest, make positive statements, repeat to strengthen and change attitudes, develop empathy, ask questions.

Define "communications" as day-to-day terms on the job.

Communication is to make known what is intended by the written or spoken word.

Why can all our communicating be said to be two-way?

It involves the practice of two complementary skills; the skill of the transmitter and the skill of the listener. Messages go back and forth on a network of which you are one station.

What does real receptiveness imply?

Familiarity with the vocabulary used, flexibility of viewpoint.

Why is timing important in communications?

It involves time as well as judgment.

Is the "why" of an order as important as the "what"?

Perceptiveness and cooperativeness increase when "why" is explained. "Why" is tied up with "what" because information precedes the "why." What and why contribute to understanding and acceptance.

How do emotions, ours and other peoples', affect the success of our communicating?

Our emotions are transferred to others with whom we have contact. Distraught people are like alarm clocks; they have high potential energy and pose a real threat as long as they are wound up. Hurried and harried conversations are distracting.

Name four general rules to follow in effective communications.

Understand the value of communication, listen attentively with an open mind, possess empathy, and create a climate for participation.

District and Section News

HAWAII

With the coming convention in mind, the nurses belonging to the County of Hawaii Association have been on a money-making spree since the beginning of the year. One project, which has been quite successful, has consisted of dinners preceding our regular business meetings with different groups acting as hostesses. A nominal fee is collected from everyone present.

In February the Puumaile nurses started the ball rolling by preparing and serving a delicious Italian dinner. Forty people enjoyed their hospitality. We were fortunate in having Mrs. Pridgen as our special guest. She filled us with enthusiasm about the convention and gave a splendid talk on planning for such an event.

In May the Hilo Memorial nurses took over and served a "Chuck Wagon" type of dinner to thirty-one hungry members and guests. In June the Public Health nurses were hostesses at a picnic supper at Coconut Island.

Once a year one of our regular meetings is held in Honokaa as a gesture of appreciation to the members from there who travel 50 miles each way every month to attend our Hilo gatherings. On April 2 twenty-four members and five guests had dinner at the Honokaa Club before our meeting.

From the sound of the above one would think all we do here is eat. However, we do accomplish quite a lot of business too!

Have you begun to put aside extra pennies for your trip to Hawaii, the Orchid Isle, in October? Here are the dates for the NATH Convention: October 3, 4, and 5. The theme is "Improving Nursing for Tomorrow." Committees and committee chairmen have been meeting regularly and we are looking forward to having a big group of nurses from all over the Territory as our guests. You will all be hearing from us a little later on. Please start planning now to visit us in October. We surely would like to show you a bit of Big Island hospitality.

* * *

Report of the Program and Arrangements Committee

The Hawaii members of the Program-Arrangements Committee have met as a group and with individual chairmen of the sub-committees.

They have decided on the Naniloa Hotel for convention headquarters. The sessions held on Thursday and Saturday will be held at the Naniloa. The section meetings which have been planned for Friday will be held at Puumaile Hospital.

The tentative program is as follows:

Oct. 2—P.M. Board Meeting

Oct. 3—A.M. House of Delegates Meeting

P.M. Panel discussion on our theme "Improving Nursing for Tomorrow." Panel members will include one R.N., PHN, M.D., Layman, Lawyer, and Psychiatric Social Worker.

For the evening of October 3, arrangements have been made for those who may wish to hear the Haili Choir to go to K.M.C. (This is subject to change.)

Oct. 4—A.M. Section Meetings

P.M. Economic Security Meeting. We are planning to have a discussion of the new Income Protection Insurance Plan. We hope also to have a couple of other speakers to talk to us on various types of investments. This session we hope to end early as we are planning a tour of the Puna lava area which will end at Warm Springs with a steak dinner.

Oct. 5—A.M. House of Delegates Meeting

P.M. Hawaii League for Nursing

Evening Banquet at the Naniloa

Oct. 6—Field trips will be offered: Nurseries around Hilo, Akaka Falls, and Volcano area.

More complete information will be forthcoming when the flyers are sent out.

Travelers:

* * *

M. Kemmerer, E. Graham, H. Flagg, and **M. Marcallino** are off to the mainland for vacations. Mrs. Marcallino has included Europe in her itinerary.

New Mothers:

Mrs. M. Kuniyoshi (Helen Miyasato) and **Mrs. K. Nakatsu** (Sun Yur Kim) both had baby boys, and **Mrs. M. Lum** (Mildred Mukai) is the mother of a baby girl.

Brides:

Miss M. Yoshimori, formerly of Kauai, is now Mrs. M. Yoshimori, and **Miss Lily Sato,** Kona District PHN, is now Mrs. Robert Leong.



CONVENTION COMMITTEE CHAIRMEN—Left to right: F. Yamanaka, M. Wilson, M. Marcallino, E. Kaaua (representing M. Barnett), S. Chang, H. Ishikawa, C. Kanuha, J. Wung, I. Clark, C. Tanaka, N. Morimoto, and E. Graham.

MAUI

Chief Jean R. Lane of the Maui County Police Department was the guest speaker at the April 18 meeting of the Maui District Nurses' Association.

In conjunction with his topic of the Civil Defense Program on Maui, Chief Lane also informed the audience of the tidal wave warning system used here in Maui County. In introducing this phase, he pointed out the difficulties encountered with the public during the past disasters of 1946 and 1957.

The United States Coast and Geodetic Survey will send tidal wave warnings through the Honolulu Police Department to the Maui Police, who in turn will warn people living on the beaches and other low coastal areas in the following manner:

1. BY SIREN. Stationary sirens and police vehicle sirens will be used. Mill whistles and other such devices may also be used. WARNING SIGNAL: *Continuous rising and lowering of siren.*
2. BY RADIO. Radio station KMVI will broadcast warnings and other official information as a public service.
3. BY POLICE OFFICERS. Officers may call at your home.
4. BY VOLUNTEERS. Persons living in strategic areas have agreed to receive telephone calls from the police and to warn those living nearby.
5. BY PLANE. When available, a plane equipped with a siren will fly over coastal areas to give warning.
6. BY YOU. When you know about a tidal wave warning, tell all those about you and keep your radio on for additional official information.
7. Kahului Development Company will notify private concerns in Central Maui interested in the affected areas.

Information available to the police when the first warning is received is usually limited to the fact that a wave *may* strike the islands at an estimated time. Under such circumstances, the police will suggest that those living on beaches or lowlands move out until all possible danger has passed. Seldom will the information received by the police be sufficient to advise removal of personal effects; this will be a matter for each individual to decide for himself.

IMPORTANT: When you hear the siren sounding the warning signal, turn on your radio to station KMVI and listen for instructions. *Do not call the police station for information.* The all clear will be broadcast by KMVI and police radio.

In Chief Lane's talk for the evening which dealt with the Civil Defense Program formerly known as the OCD (Office of Civilian Defense), he presented this view regarding to an air attack. The people should remain at their homes and not congregate in large groups primarily for the sake of offering security for children and adults in a familiar location, whereby sanitary facilities would be available and there would be less chance of epidemics starting.

The definition of Civil Defense used that evening was "planning to use the community resources for yourself." In this respect, Chief Lane emphasized organizing government and private bodies in one unit for Maui County.

The American Red Cross, Department of Public Instruction, Plantations, and Medical Society have already contributed towards this nucleus. At this date, the 40-page manual of Civil Defense facilities compiled by the Maui County Police Department has been distributed and additional copies will be available at a later date.

Much was learned by this informative talk which concluded with a discussion of the possible role and contribution of the MDNA to the wheel of Civil Defense on Maui.

* * *

New Members:

Mrs. Rowena Parsons has transferred from Hawaii and is now employed at the Central Maui Memorial Hospital as night staff nurse in the Maternity Department. **Miss Anne Shick** is the new OR nurse at Kula Sanatorium. She was formerly in the U. S. Army Nurse Corps and is a veteran of the Korean Campaign. **Mrs. Ramona Morgan Hess, Misses Yukiko Oshiro** and **Grace Arakawa,** alumnae from St. Francis School of Nursing, have joined the CMMH nursing staff.

New Mother:

Toshie Kohatsu Nako has named the handsome addition to the Nako family Clifford Toshinaru. He arrived February 10.

Travelers:

Setsuyo Ushiro and **Masami Shiraki** went to Hawaii for a preconvention tour.

Mrs. Ruth Suzuki, Mrs. Anne Gillin, and Mrs. Hilda Akana, Chairman, were elected to the Nominations Committee.

MDNA had a picnic on July 18 for the senior students entering the schools of nursing.

The members of the MDNA were invited to a tea at the home of their fellow member, Mrs. Marion Wright, at Oluwalu, Lahaina. She is at present assisting the Future Nurses' Association of America club in her community. The club members have assisted with Blood Bank and Poliomyelitis Immunization drives as community projects. They are also engaged in hospital work at Pioneer Hospital where they report for duty in yellow uniforms with blue cross patches on their pockets. Stress is laid on punctuality, dependability, cleanliness, and poise. A merit system is also being used. After 50 hours of service, the member is eligible to receive her yellow and white cap as a part of her uniform.

With the objective of cooperating and contributing towards the health aspect of the community, the MDNA joined the Maui Chamber of Commerce. Their ambassador this year is Mrs. Anne Gillin, Industrial Nurse at Maui Pineapple Company's Kahului Dispensary.

Program Chairman, Mrs. Marjorie Okinaka, was recently the guest lecturer at the Baldwin High School Nursing, Beta Phi Nu, luncheon meeting.

OAHU

Brides:

Doris Gregory, Educational Director at The Queen's Hospital and Associate Editor of the *Inter-Island Nurses' Bulletin,* was married at 4:00 P.M. on June 1 in a beautiful ceremony to Mr. Michael Beccio, electronics engineer at the Barber's Point Naval Air Base. A reception was held at the Halekulani Hotel. Mrs. Estelle Gregory, the bride's mother, arrived on the *Leilani* to attend the wedding. The newlyweds are living at 1547 Ala Wai Blvd.

Miss Mary Marshall, Director of Nursing of Children's Hospital, became Mrs. Alex J. Walsh on June 29 at St. Anthony's Church. A reception was held at the Oahu Country Club. Mrs. Walsh will resign her position on August 15. The newlyweds are at home at 392 Dune Circle, Kailua.

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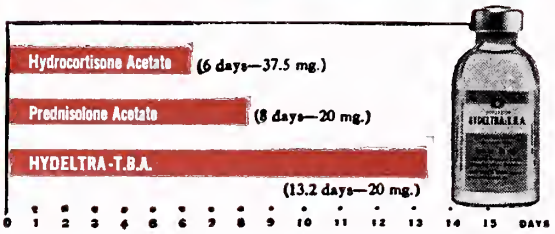
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(1) Holt, J. O. S., Jr.: Dallas Med. J. 42:497, 1956. (2) Gelvin, E. P.; McGavack, T. H., and Kenigsberg, S.: Am. J. Digest. Dis. 1:155, 1956. (3) Natenshon, A. L.: Am. Pract. & Digest Treat. 7:1456, 1956.

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IN MEMORIAM

(*Continued from page 643*)

tal in building a new Paia Hospital (now the Children's Home). He was also a strong factor in starting Kula Sanatorium and was in charge of this institution at first, until a resident physician was secured.

Early in his Maui days, Dr. McConkey became interested in Masonry and was a member of that order from its inception there. He attained the 33rd degree and was also a Shriner.

Late in 1916 Dr. McConkey decided to return to the mainland to specialize in surgery, which was his primary interest in life. After a year of postgraduate work at his alma mater in Chicago, he set up practice in St. Louis, Missouri, in June 1917.

On September 20, 1936, after a lingering illness, Dr. McConkey died, and was buried in St. Louis. The Masonic service was sponsored by Maui Lodge F. & A. M., which he considered "home" for his entire lifetime.

NOTES AND NEWS

(*Continued from page 648*)

Winners at skeet shooting

Dr. William Wilson turned in a perfect score to win the Kuliouou Skeet Club shoot.

. . . at golf

Drs. Homer Izumi and **Samuel L. Yee** won the team Stableford Tournament with 86 points.

Dr. M. E. Stevens scored 69-7, 62 net, to win the Oahu Country Club sweepstakes on May 29.

Invitations to dinner

were extended to Hawaii Medical Association members and their wives to attend a banquet on June 28 at the Reef Hotel in honor of Mr. John E. McKeen, president of the Pfizer Company.

NEWS

Medical Library News

For some time, it has been a matter of concern to our scientists that translations of Russian medical and scientific articles have not been easily obtainable because of the cost involved. The Senate Appropriations Committee investigated the situation and reported that: "Failure to promptly make available to American scientists the full findings of Russian scientists opens the door to useless duplication of work, waste of time and money, and delay in grappling effectively with the major disease problems of today."

The National Institutes of Health were therefore given funds and commissioned to arrange free distribution to medical libraries of translated copies of the most important Russian journals as follows:

Biochemistry
Biophysics
Bulletin of Experimental Biology and Medicine
Journal of Microbiology, Epidemiology and Immunobiology
Problems of Hematology and Blood Transfusion
Problems of Oncology
Problems of Virology
Sechenov Physiological Journal

In addition to this, Excerpta Medica will publish *Abstracts of Soviet Medicine,* a quarterly, and Academic Press will bring out a Russian-English medical dictionary in the near future.

All of this material will be available in the Medical Library, and it is hoped that our doctors and research workers will make good use of it.

Urology Award

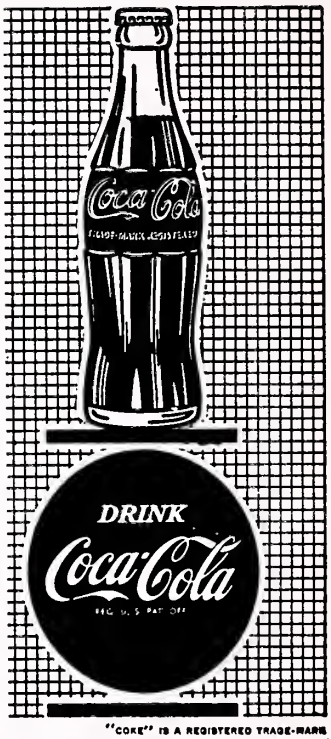
The American Urological Association offers an annual award of $1000 (first prize of $500, second prize $300, and third prize $200) for essays on the result of some clinical or laboratory research in Urology. Competition shall be limited to urologists who have been graduated not more than ten years, and to hospital interns and residents doing research work in Urology.

For full particulars write the Executive Secretary, William P. Didusch, 1120 North Charles Street, Baltimore, Maryland. Essays must be in his hands before December 1, 1957.

Postgraduate Course

New York Medical College announces a postgraduate course in pediatric allergy under the direction of Bret Ratner, M.D., Professor of Clinical Pediatrics and Associate Professor of Immunology, from November 6, 1957, to May 28, 1958, on Wednesdays, 9 A.M. to 4 P.M. Fee is $300.00.

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*REFERENCE: J.A.M.A. 163: 359, 1957 (February 2)

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BOOK REVIEWS

(*Continued from page 647*)

The Recurrent Laryngeal Nerves in Thyroid Surgery.

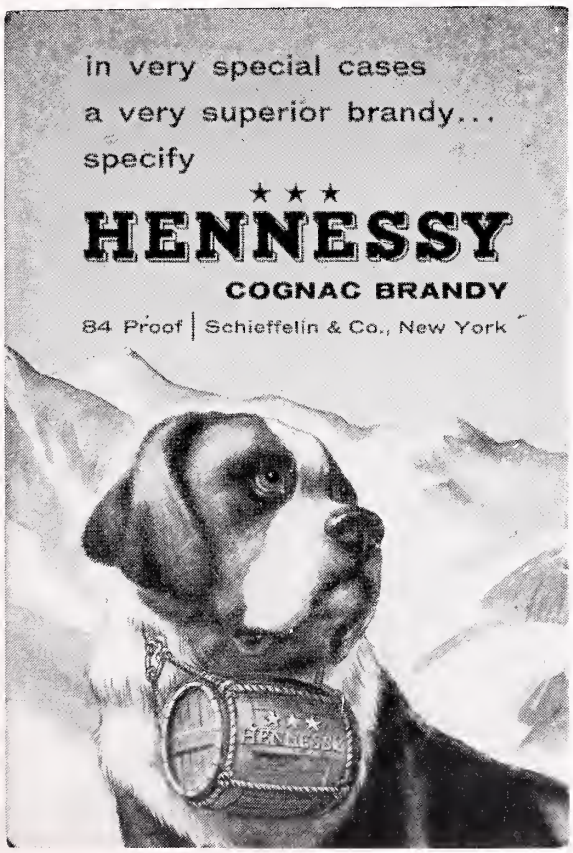
By William H. Rustad, M.D., 47 pp., illus., Price $4.50, Charles C. Thomas, 1956.

This monograph will be of particular interest to those who do thyroid surgery. It records the author's observations on the anatomical variations found in the dissection of 200 recurrent laryngeal nerves. These dissections were carried out on 100 cadavers and no doubt include most of the variations that occur in the extralaryngeal course of these important structures. One variation, the non-recurrent inferior laryngeal nerve, was apparently not observed and is not mentioned.

The numerous illustrations depict well the diverse relationships possible between the single or branching recurrent nerve with the single or branching inferior thyroid artery, and yet the author seems to hedge the obvious recommendation in his statement that the surgeon can avoid injury to these variable nerves by "staying away from the danger areas." Proper emphasis is given, however, to the importance of meticulous dissection in a bloodless field when it is necessary to approach the nerve.

The author seems to be pessimistic, too, regarding the ability of a surgeon to adequately identify the nerve variations and suggests that they not be dissected out for fear of injury to some of the filaments. In the reviewer's opinion, this dissection is feasible if started from below and is especially important where the variations do exist, a fact that no one can predict in advance.

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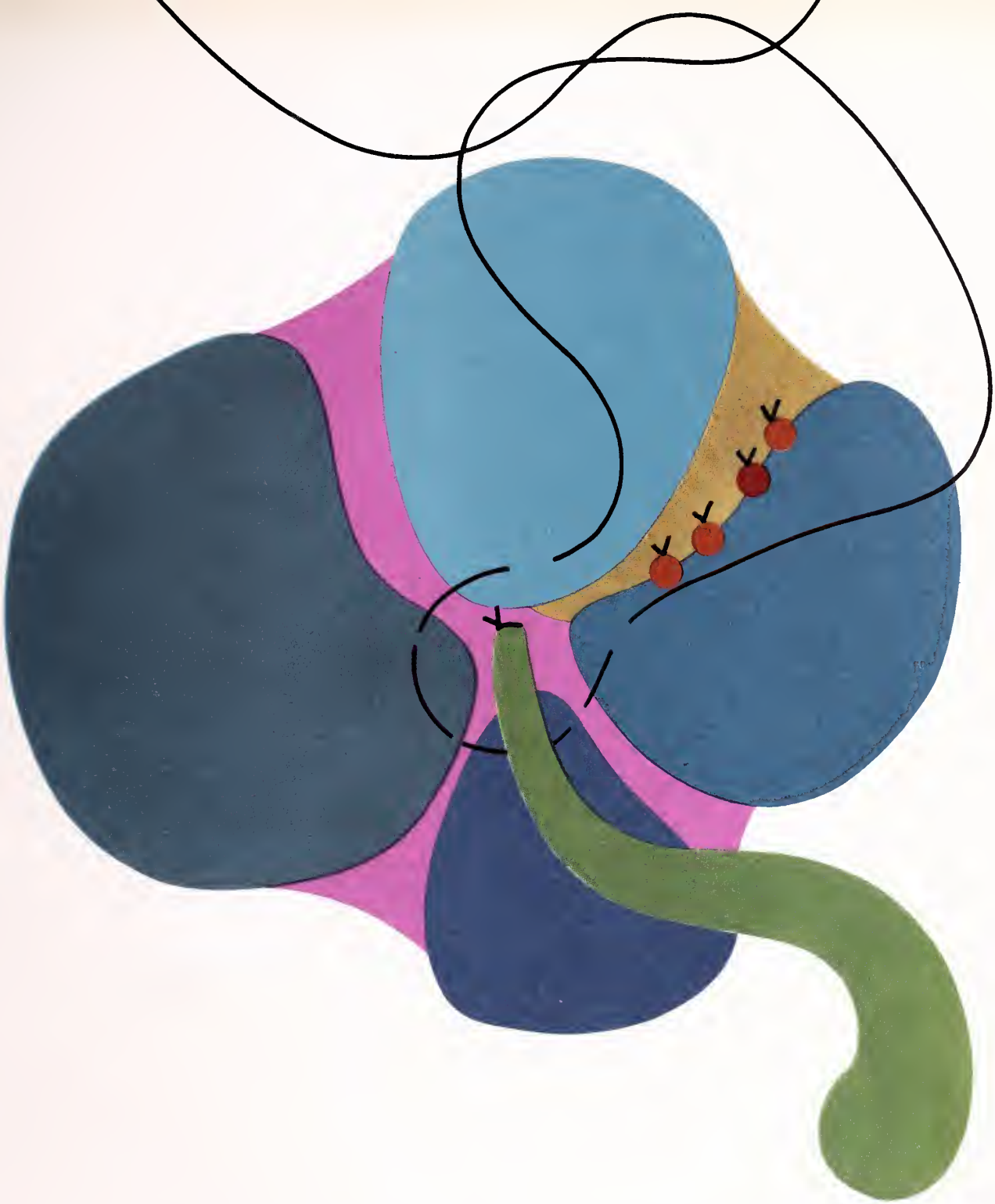
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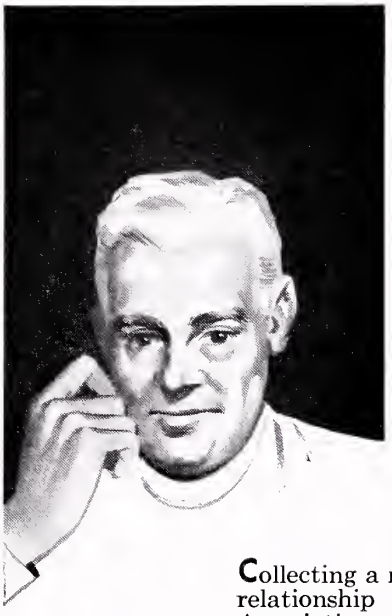
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more than 40 u./day . . . reduce insulin 20% immediately; carefully reduce insulin beyond this point if response to Orinase is observed. In these patients, hospitalization should be considered during the transition period.

Caution: During the initial "test" period (not more than 5 to 7 days), the patient should test his urine for sugar and ketone bodies three times daily and report to his physician daily. For the first month, he should report at least once weekly for physical examination, blood sugar determination, and white cell count (with differential count, if indicated). After the first month, the patient should be seen at least once a month, and the above studies carried out.

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Indications. Orinase is most likely to benefit the patient in whom the diabetes is relatively mild and stable, is not adequately controlled by dietary restrictions alone, and developed sometime after the age of 30 years.

Contraindications. Orinase is contraindicated in patients with 1) diabetes of the type known variously as juvenile, growth-onset, unstable, or brittle; 2) a history of diabetic coma; 3) diabetes complicated by ketosis, acidosis, coma, fever, severe trauma, gangrene, Raynaud's disease, or serious impairment of renal or thyroid function; 4) hepatic dysfunction; and 5) diabetes adequately controlled by dietary restriction.

Effects. In patients with a satisfactory response to Orinase, the blood sugar falls, glycosuria diminishes, and such symptoms as pruritus, polyuria, and polyphagia disappear. It is *not* a substitute for insulin. And it requires the same adherence to basic principles of diabetes control as does insulin, e.g., dietary regulation; tests for glycosuria and ketonuria; hygiene; exercise; instruction of the patient to recognize and counteract impending hypoglycemia, to follow rigidly directions regarding diet and continuing use of the drug and to report immediately to the physician any feeling of illness. Extreme care must be taken during the transition period to avoid ketosis, acidosis, and coma.

Side effects. To date, the most serious side effect is hypoglycemia, which may occur occasionally and is most likely to occur during the transition period from insulin to Orinase. Other untoward reactions to Orinase are rare, usually of a nonserious nature, and tend to disappear on adjustment of dosage, e.g., gastrointestinal disturbances, headache, variable allergic skin manifestations, and alcohol intolerance.

Clinical toxicity. Aside from an occasional hypoglycemia, Orinase appears to be remarkably free of gross clinical toxicity. There is no evidence of crystalluria or other untoward effects on renal function, or of hepatotoxicity. Except for a rare leukopenia of mild degree, which has been reversible (in some instances, even under continued therapy), there have been no adverse effects on hematopoietic function.

*TRADEMARK, REG. U. S. PAT. OFF.

CASE REPORT

(*Continued from page 636*)

"crystoids" anthelmintic was ineffective. On May 27 the patient was admitted to the hospital for treatment with oral $MgSO_4$ and 5 grams of oleoresin of aspidium in divided doses. She had several watery stools after treatment, and examination of these stools revealed several small and partially degenerated stellantchasmus falcatus flukes measuring about 0.5 mm long by 0.2 mm wide (Fig. 1). The ova were two and a half to three times the size of a leucocyte (average size of ova 18 to 30 by 15 to 17 microns).

It is precisely the minute size of the ova which may cause serious pathology. Serial sections of myocardium of patients dying with cardiac decompensation and valvulitis[2] have shown ova emboli and sclerosis as apparent cause; ova have been found also in dural and subdural hemorrhages lateral to the spinal cord coexistent with ova in myocardial lesions at autopsy following sudden death.[3]

The present patient recalls eating raw mullet caught between Hauula and Punaluu in May, 1956. This is the usual manner of human infection. The trematode first parasitizes a snail, then encysts in the musculature of the fish after penetrating beneath the scales.[4] Following treatment the patient feels completely relieved of all symptoms, her stools being reported by the original technician to be now free of ova. Because of the potential symptomatology and pathology in many systems due to this infection, and because ordinary stool examination may not reveal presence of the parasite, this case is considered significant.

[2] Africa, C. M., de Leon, W., and Garcia, E. Y.: Visceral Complications in Intestinal Heterophyidiasis of Man, Acta Med. Philippina Monogr. Ser. 1:37 (June) 1940.

[3] Ibid, p. 38.

Summary

A case of human infection by heterophyid flukes is reported. In view of the known presence of infected mullet in the Island of Oahu and presence in the population of persons of many cultures in which eating raw fish is customary, there is a strong possibility that heterophyidiasis in Hawaii is more common than generally suspected; this condition may cause symptoms and pathology in several systems of the body and has been reported to be a cause of sudden death in the Philippine Islands. The fluke ova may be overlooked by routine stool examinations due to their minute size.

[4] Mackie, T. T., Hunter, G. W., and Worth, C. B.: A Manual of Tropical Medicine, Philadelphia, W. B. Saunders Co., 1945, pp. 391-396, 399-400.

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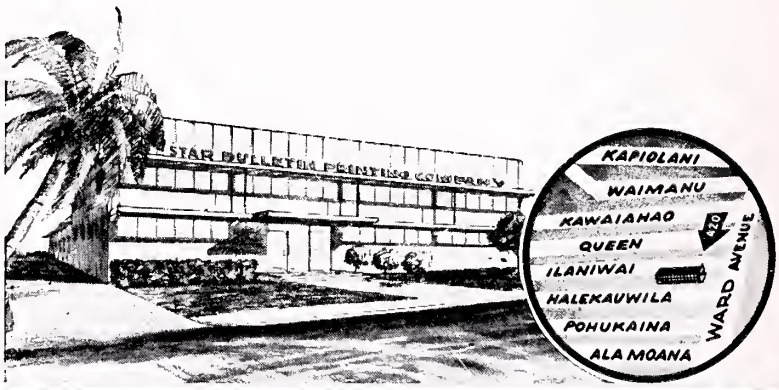
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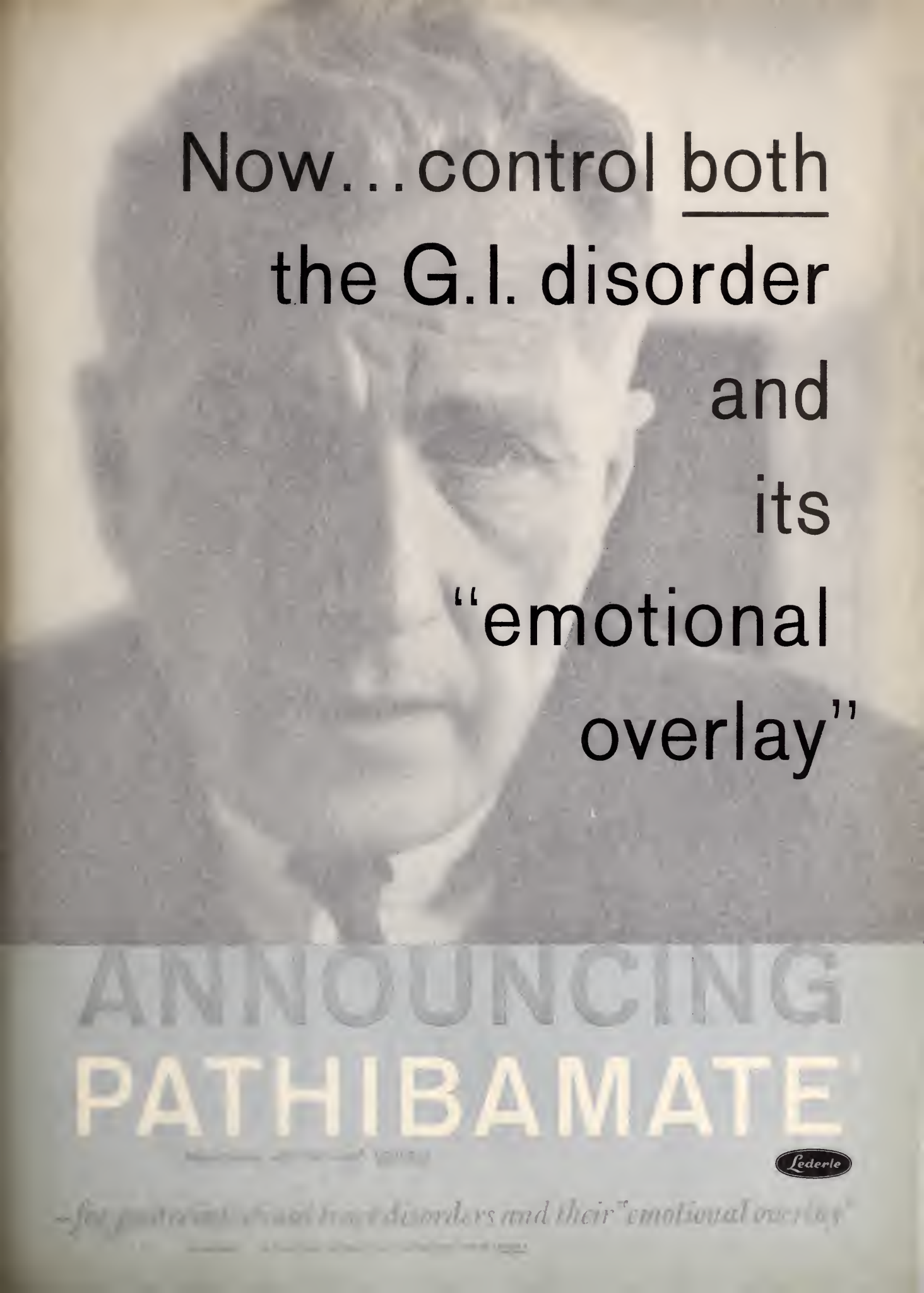
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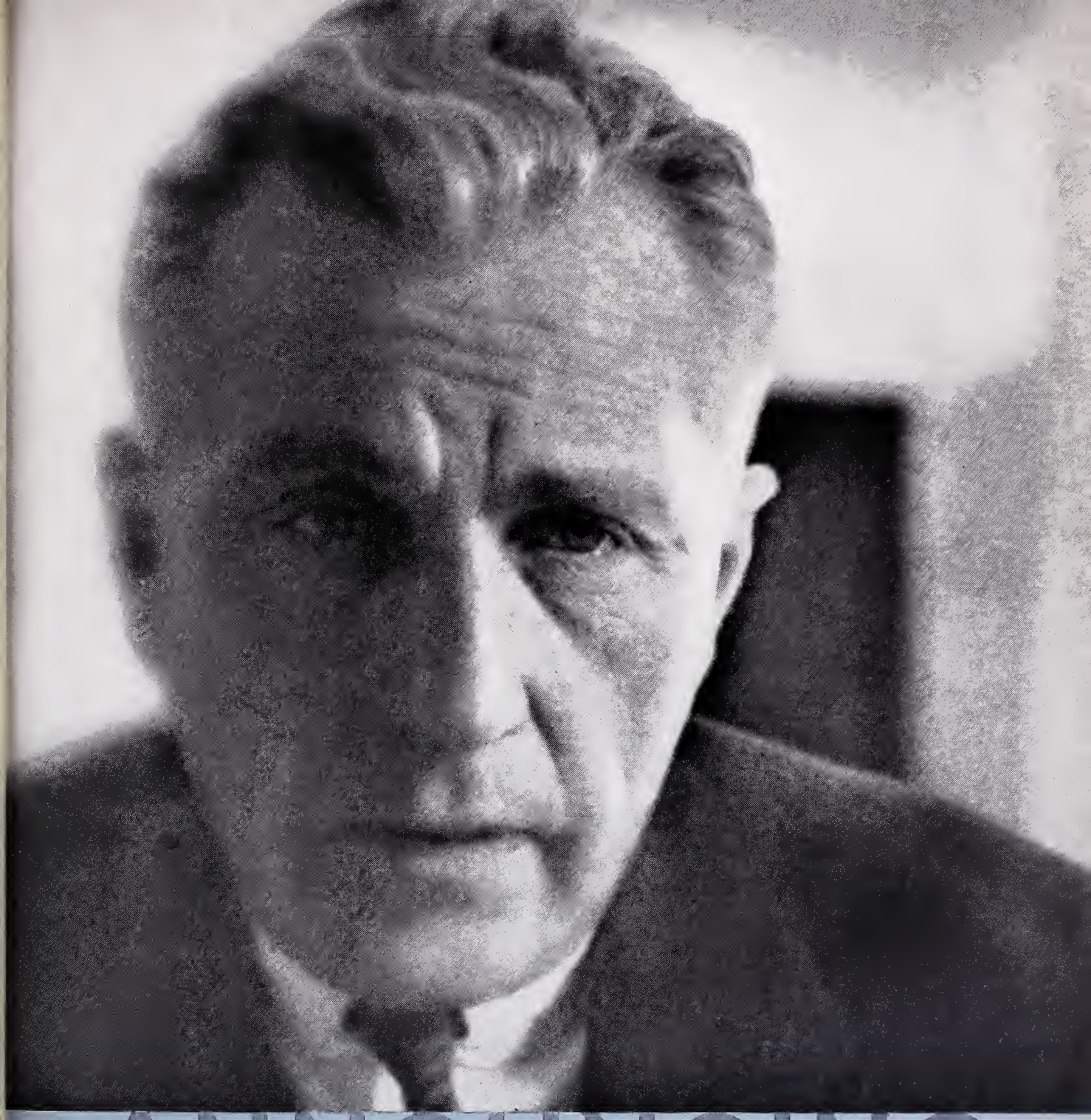
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*Ferguson, J. T., and Linn, F. V. Z.: Antibiotic Med. & Clin. Therapy *3*:329, 1956.

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1. Cornbleet, T., and Barsky, S.: The Role of the Tranquilizing Drugs in Dermatology, presented at 115th Annual Meeting of Illinois State Medical Society, May 19, 1955.

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